City Of Springfield

Preferred Plan

Group No.: G0020720

Preferred 300+25 VAR

March 26, 2013

City of Springfield

By:

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Human Resources Director

Third Party Administrative Services Provided By:

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INTRODUCTION

Welcome to your City of Springfield (also referred to as 'the *employer*' or '*employer*') group health plan. Your *employer* offers this coverage to help you and your family members stay well, and to protect you in case of *illness* or *injury*. Your *plan* includes a wide range of benefits and services, and we hope you will take the time to become familiar with them.

Your *employer, who is also the Plan Sponsor,* has prepared this document to help you understand how your *plan* works and how to use it. This document summarizes the benefits provided under the Preferred Plan (referred to as 'the plan' or 'this plan' throughout this document). Please read it carefully and thoroughly. Your benefits are affected by certain limitations and conditions, which require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

The *plan* is an employee welfare benefit *plan* within the meaning of ERISA. The *plan* is a self-insured medical *plan* intended to meet the requirements of Sections 105(b), 105(h), and 106 of the Internal Revenue Code so that the portion of the cost of coverage paid by your *Plan Sponsor*, and any benefits received by you through this *plan*, are not taxable income to you. Your specific tax treatment will depend on your personal circumstances; the *plan* does not guarantee any particular tax treatment. You are solely responsible for any and all federal, state, and local taxes attributable to your participation in this *plan*, and the *plan* expressly disclaims any liability for such taxes.

The plan is 'self-insured,' which means benefits are paid from your *employer*'s general assets and or trust funds and are not guaranteed by an insurance company. The *Plan Sponsor* has contracted with a *Third Party Administrator* to perform certain administrative services related to this plan.

PacificSource Administrators, Inc. is the *Third Party Administrator and* provides administrative services for this plan on behalf of the *Plan Sponsor*. If anything is unclear to you, PacificSource staff are available to answer your questions. Please give them a call or visit them on the Internet. PacificSource looks forward to serving you and your family.

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This document serves as the written Plan document and Summary Plan Description (SPD). It is very important that you review the entire document carefully to confirm a complete understanding of the benefits available, as well as your responsibility, under the plan.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Plan Terms and Definitions section. This document explains the services covered by the plan; the benefit summaries tell you how much this plan pays toward expenses and amounts for which you are responsible.

As used in this document, the word 'year' refers to the *benefit year*, which is the 12-month period beginning January 1 and ending December 31. The word *lifetime* as used in this document refers to the period of time you or your eligible dependents participate in this plan or any other *Plan sponsored* by the *Plan Sponsor.*

Any amount you or your eligible dependents have accumulated toward the benefit maximum amounts, deductible, or out-of-pocket maximum of any immediately prior *plan sponsored* by the *Plan Sponsor* will be counted toward the benefit maximum amounts of this plan. In addition, any time accumulated toward satisfaction of a *waiting period* of the *preexisting condition* limitation period under an immediately prior plan will be counted toward satisfaction of the *waiting period* or *preexisting condition* limitation period of this plan.

The *Plan Sponsor* reserves the right to amend, modify, or terminate this plan in any manner, at any time, which may result in termination or modification of your coverage. If this plan is terminated, any plan assets will be used to pay for eligible expenses *incurred* prior to the plan's termination, and such expenses will be paid as provided under the terms of this plan prior to termination. If there is any conflict between this document and the underlying plan document(s), the plan document(s) control.

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MEDICAL BENEFIT SUMMARY Preferred Plan

POLICY INFORMATION

Group Name: City of Springfield

Group Number: G0020720

Plan Name: Preferred Plan – Preferred 300+25 VAR

Provider Network: PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: Twenty (20) Hours

Waiting Period for New Employees: Per Employer Policy

MEDICAL BENEFIT SUMMARY

ANNUAL DEDUCTIBLE.....$300 per person / $900 per family
The deductible is an amount of covered medical expenses the member pays each benefit year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with an asterisk (*). Once a member has paid a total amount toward covered expenses during the benefit year equal to the per person amount listed above, the deductible will be satisfied for that person for the rest of that benefit year. Once any covered family members have paid a combined total toward covered expenses during the benefit year equal to the per family amount listed above, the deductible will be satisfied for all covered family members for the rest of that benefit year. Deductible expense is not applied to the out-of-pocket limit.

ANNUAL OUT-OF-POCKET LIMIT
Participating Providers .....$2,000 per person / $4,000 per family
Nonparticipating Providers .....$5,000 per person
Only participating provider expense applies to the participating provider out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the copayment is deducted) for participating and network not available providers for the rest of that benefit year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the copayment is deducted) for nonparticipating providers for the rest of that benefit year. Deductibles, copayments, transplant services, benefits paid in full and nonparticipating provider charges in excess of the allowable fee do not accumulate toward the out-of-pocket limit. Copayments and nonparticipating provider charges in excess of the allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

The member is responsible for the above deductible and the following copays and coinsurance.

SERVICE:	***PARTICIPATING PROVIDERS/ NETWORK NOT AVAILABLE:***	***NONPARTICIPATING PROVIDERS:***
PREVENTIVE CARE		
Well Baby/Well Child Care	No charge*	20% coinsurance*
Routine Physicals	No charge*	20% coinsurance*
Well Woman Visits	No charge*	20% coinsurance*
Immunizations	No charge*	20% coinsurance*
Routine Colonoscopy	No charge*	40% coinsurance
Prostate Cancer Screening	No charge*	40% coinsurance
PROFESSIONAL SERVICES		
Office and Home Visits	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Office Procedures and Supplies	No charge*	20% coinsurance*
Surgery	20% coinsurance	40% coinsurance
Outpatient Rehabilitation Services	20% coinsurance	30% coinsurance

SERVICE:	*PARTICIPATING PROVIDERS/ NETWORK NOT AVAILABLE:*	*NONPARTICIPATING PROVIDERS:*
HOSPITAL SERVICES		
Inpatient Room and Board	20% coinsurance	40% coinsurance
Inpatient Rehabilitation Services	20% coinsurance	40% coinsurance
Skilled Nursing Facility Care	20% coinsurance	40% coinsurance
MATERNITY SERVICES		
Office and Home Visits	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Inpatient Room and Board	20% coinsurance	40% coinsurance
Outpatient Services	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES		
Outpatient Surgery/Services	20% coinsurance	40% coinsurance
Advanced Diagnostic Imaging	20% coinsurance	40% coinsurance
Diagnostic/Therapeutic Radiology/Lab	20% coinsurance*	40% coinsurance*
URGENT AND EMERGENCY SERVICES		
Urgent Care Center Visits	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Emergency Room Visits	$100 copay/visit plus 20% coinsurance*^	$100 copay/visit plus 40% coinsurance*^
Ambulance, Ground	20% coinsurance	20% coinsurance
Ambulance, Air	50% coinsurance	50% coinsurance
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Inpatient Care	20% coinsurance	40% coinsurance
Residential Programs	20% coinsurance	40% coinsurance
OTHER COVERED SERVICES		
Allergy Injections	$5 copay/visit*	$5 copay/visit plus 20% coinsurance*
Durable Medical Equipment	20% coinsurance	50% coinsurance
Home Health Care	20% coinsurance	50% coinsurance
Temporomandibular Joint (TMJ) Services	50% coinsurance	50% coinsurance
Alternative Care and Chiropractic	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*

^ Copay waived if admitted into hospital. For emergency medical conditions, nonparticipating providers are paid at the participating provider level.

* ***Not subject to annual deductible.***

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge (see 'allowable fee' in the Definitions section) for the geographical area in which the charge is incurred.

PHARMACY BENEFIT SUMMARY

Your health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. Your prescription drug plan qualifies as creditable coverage for Medicare Part D.

MEMBER COST SHARE (other than for Specialty Drugs)

Each time a covered pharmaceutical is dispensed, you are responsible for the copayment and/or coinsurance below:

From a participating retail pharmacy using your Plan Sponsor's Pharmacy Program (see below):	**Tier 1: Generic**	**Tier 2: Formulary**	**Tier 3: Non-formulary**
Up to a 30-day supply:	$15	$30	$50
31 to 60-day supply:	$30	$60	$100
61 to 90-day supply:	$45	$90	$150
From a participating mail order service (see below):			
Up to a 30-day supply:	$15	$30	$50
31 to 90-day supply:	$37.50	$75	$125
From a participating retail pharmacy without using your Plan Sponsor's Pharmacy Program, or from a nonparticipating pharmacy (see below):	50% or the retail copayment above, whichever is greater		

MEMBER COST SHARE FOR SPECIALTY DRUGS

Each time a covered specialty drug is dispensed, you are responsible for the copayment and/or coinsurance below:

From the participating specialty pharmacy:	
Up to a 30-day supply:	$100 copay/prescription or 20% coinsurance, whichever is less
From a participating retail pharmacy, from a participating mail order service, or from a nonparticipating pharmacy or pharmaceutical service provider:	Not covered (except 5-day emergency supply)

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED

Unless the physician requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by Oregon law. If the member receives a brand name drug when a generic is available, the member will be responsible for the brand name drug's copayment plus the difference in cost between the brand name drug and its generic equivalent. If the physician requires the use of a brand name drug, the prescription will be filled with the brand name drug and the member will be responsible for the brand name drug's copayment and/or coinsurance.

USING YOUR *PLAN SPONSOR*'S PHARMACY PROGRAM

Retail Pharmacy Network

To use your *Plan Sponsor*'s Pharmacy Program, you must show the pharmacy plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level. When obtaining prescription drugs at a participating retail pharmacy, your *Plan Sponsor*'s Pharmacy Program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate copayment from you and bill PacificSource electronically for the balance.

Mail Order Service

This plan includes a participating mail order service for prescription drugs. Most, but not all, covered prescription drugs are available through this service. Questions about availability of specific drugs may be directed to the PacificSource Customer Service Department or to the plan's participating mail order service vendor. Forms and instructions for using the mail order service are available from PacificSource and at psa.pacificsource.com.

Specialty Drug Program

PacificSource contracts with a specialty pharmacy services provider for high-cost injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to our *members* with prescriptions for specialty medications by providing them strong clinical support, as well as the best drug pricing for these specific medications and biotech drugs. The CareTeam also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries.

Participating provider benefits for specialty drugs are available when you use the specialty pharmacy services provider. Specialty drugs are not available through the participating retail pharmacy network or mail order service. More information regarding the exclusive specialty pharmacy services provider and health conditions and a list of drugs requiring preauthorization and/or are subject to pharmaceutical service restrictions is on psa.pacificsource.com.

OTHER COVERED PHARMACEUTICALS

Supplies covered under pharmacy are in place of, not in addition to, those same covered supplies under the medical plan. *Member* cost share for items in this section are applied on the same basis as for other prescription drugs, unless otherwise noted.

Diabetic Supplies

- Insulin, diabetic syringes, lancets, and test strips are available.
- Glucagon recovery kits for your plan's formulary copayment.
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit.

Contraceptives

Any deductible, copayment, and/or coinsurance amounts are waived for all Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to regular pharmacy plan benefits. When no generic exists, preferred brand is covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under preventive care.

Tobacco Cessation

Any deductible, copayment, and/or coinsurance amounts listed above are waived for program specific tobacco cessation medications with active participation in a plan approved tobacco cessation program (see Preventive Care in the policy's Covered Expenses section).

Orally Administered Anticancer Medications

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are available. Copayments for orally administered anticancer medication are applied on the same basis as for other drugs. Orally administered anticancer medications covered under the pharmacy plan are in place of, not in addition to, those same covered drugs under the medical plan.

Treatment of Glaucoma

Early refills of prescription eye drops for treatment of glaucoma are allowed under the following circumstances:

1. If the member requests refill less than 30 days after the date the original prescription was dispensed to the insured; and

2. The prescriber indicates on the original prescription that a specific number of refills will be needed;

3. The refill does not exceed the number of refills that the prescriber indicated; and

4. If the prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license, except for:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription.
  - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs except as allowed under Clinical Trials, and drugs available without a prescription (even if a prescription is provided).
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but are covered under the medical plan's office supply benefit.
  - Immunizations (although not covered by this pharmacy benefit, immunizations may be covered under the medical plan's preventive care benefit).
  - Drugs and devices to treat erectile dysfunction.
  - Drugs used as a preventive measure against hazards of travel.
  - Vitamins, minerals, and dietary supplements, except for prescription prenatal vitamins and fluoride products, and for services that have a rating of 'A' or 'B' from the U.S. Preventive Services Task Force (USPSTF).

- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on www.pacificsource.com/drug-list.

- Certain drugs are subject to step therapy protocols. An up-to-date list of drugs subject to step therapy protocols is available on www.pacificsource.com/drug-list.

- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.

- Quantities for any drug filled or refilled are limited to no more than a 90-day supply when purchased at retail pharmacy or a 90-day supply when purchased through mail order pharmacy service or a 30-day supply when purchased through a specialty pharmacy.

- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using your *Plan Sponsor*'s Pharmacy Program, reimbursement is limited to an allowable fee.

- The member cost share for prescription drugs (copayments, coinsurance, and service charges) does not apply to the medical deductible or out-of-pocket limit of the policy. You continue to be responsible for the prescription drug copayments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.

- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment–Coordination of Benefits)

ALTERNATIVE CARE BENEFIT SUMMARY

Your plan's alternative care benefit allows you to receive treatment from the licensed alternative care providers listed below for medically necessary diagnosis and treatment of illness or injury. Refer to the Medical Benefit Summary for your copayment and/or coinsurance information.

PacificSource contracts with a network of alternative care providers, so you can reduce your out-of-pocket expense by using one of the Participating Providers. For a listing of participating alternative care providers in your area, please refer to your plan's Participating Provider directory, please refer to asocustomerservice@pacificsource.com, or call PacificSource's Customer Service Department.

Covered Services

- Services of a licensed naturopath for medically necessary diagnosis and treatment of illness or injury.
- Acupuncture services of a licensed acupuncturist (under ORS677.757 to ORS677.770) or physician when necessary for diagnosis and treatment of illness or injury.
- Services of a licensed chiropractor for medically necessary diagnosis and treatment of illness or injury, including chiropractic manipulations and chiropractic massage therapy.
- Services of a licensed massage therapist for medically necessary treatment of myofascial, neuromusculoskeletal or pain syndromes are also covered.

The combined benefit for all treatments, services, and supplies provided or ordered by an alternative care provider is limited to $1,000 per person in any benefit year. That amount includes, but is not limited to, covered charges for any laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by an alternative care provider.

Excluded Services

- Any service or supply excluded or not otherwise covered by the medical plan.
- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care provider.
- Services of an alternative care provider for pregnancy or childbirth.

VISION BENEFIT SUMMARY

Your group health plan covers vision exams, eyeglasses, and contact lenses for both routine and emergency eye services in an office setting. The following shows the vision benefit available.

Benefit Period

Eye Exam: One exam every 12 months age 17 and younger, one exam every 24 months for age 18 and older

Lenses: One pair every 12 months age 17 and younger, one pair every 24 months for age 18 and older

Frames: One every 12 months age 17 and younger, one every 24 months for age 18 and older

Contact Lenses: One pair (or disposable contacts up to the dollar maximum) every 12 months age 17 and younger, one pair (or disposable contacts up to the dollar maximum) every 24 months for age 18 and older

Member Responsibility

SERVICE/SUPPLY	PARTICIPATING PROVIDERS:	NONPARTICIPATING PROVIDERS:
Eye Exam	No charge	No charge up to $40 maximum benefit
Hardware		
Lenses (maximum per pair)		
Single Vision	No charge	No charge up to $56 maximum benefit
Bifocal	No charge	No charge up to $84 maximum benefit
Trifocal	No charge	No charge up to $116 maximum benefit
Lenticular	No charge	No charge up to $236 maximum benefit
Progressive	No charge up to $116 maximum benefit	No charge up to $116 maximum benefit
Frames	No charge up to $75 maximum benefit	No charge up to $75 maximum benefit
Contacts (in place of glasses)	No charge up to $131 maximum benefit	No charge up to $131 maximum benefit

The amounts listed above are the maximum benefits allowed for all vision exams, lenses, and frames furnished during any benefit period when prescribed by a licensed ophthalmologist or licensed optometrist. If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If only one lens is supplied, the allowance for the lens is 50% of the lens allowance shown. Participating providers discount hardware services.

Limitations and Exclusions

The out-of-pocket expense for vision services (copayments and service charges) does not apply to the medical plan's deductible or out-of-pocket limit. Also, the member continues to be responsible for the vision copayments and service charges regardless of whether the medical plan's out-of-pocket limit is satisfied.

Outside the PacificSource service area and in areas where our members do not have reasonable access to a participating provider (see the Network Not Available Benefits section of the Summary Plan Document), the allowable fee is based on 100% of usual, customary, and reasonable charge (UCR).

Covered expenses do not include, and no benefits are payable for:

- Special procedures such as orthoptics or vision training
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids
- Tint
- Plano contact lenses
- Anti-reflective coatings and scratch resistant coatings
- Separate charges for contact lens fitting
- Replacement of lost, stolen, or broken lenses or frames

- Duplication of spare eyeglasses or any lenses or frames
- Nonprescription lenses
- Visual analysis that does not include refraction
- Services or supplies not listed as covered expenses
- Eye exams required as a condition of employment, or required by a labor agreement or government body
- Expenses covered under any worker's compensation law
- Services or supplies received before this plan's coverage begins or after it ends
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the *Plan Sponsor*
- Medical or surgical treatment of the eye

Important information about your vision benefits

Your group health plan includes coverage for vision services, including prescription eyeglasses and contact lenses. To make the most of those benefits, it's important to keep in mind the following:

- **Participating Providers:** PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

- **Paying for Services:** Please remember to show your current PacificSource ID card whenever you use your plan's benefits. Our provider contracts require participating providers to bill us directly whenever you receive covered services and supplies. Providers normally call PacificSource to verify your vision benefits, and then bill us directly. Participating providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over your plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and should bill PacificSource directly.

- **Sales and Special Promotions:** Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because participating providers already discount their services through their contract with PacificSource, your plan's participating provider benefits cannot be combined with any other discounts or coupons. You can use your plan's participating provider benefits, or you can use your plan's nonparticipating provider benefits to take advantage of a sale or coupon offer. If you do take advantage of a special offer, the participating provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's nonparticipating provider benefits.

BECOMING ELIGIBLE

Who Pays for Your Benefits

The *Plan Sponsor* shares the cost of providing benefits for you and your enrolled dependents. From time to time, the *Plan Sponsor* may adjust the amount of contributions required for coverage. In addition, the deductibles and *copayments* may also change periodically. You will be notified by your *Plan Sponsor* of any changes in the cost of plan coverage before they take effect.

Who is Eligible

Employees – You are eligible to participate in this plan if you are a regular, full-time employee of the *Plan Sponsor* upon the completion of the minimum number of hours and probationary waiting period set by your *Plan Sponsor*. Your *Plan Sponsor's* eligibility requirements are stated in your Medical Benefit Summary. All employees who meet those requirements are eligible for coverage**.**

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility. Status as an employee is determined under the employment records of the *Plan Sponsor*. Workers classified by the *Plan Sponsor* as independent contractors are not eligible for this plan under any circumstances.

Retirees – You are eligible to participate in this plan if you are a retired employee of the *Plan Sponsor*, or a spouse of a retired employee. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Dependents – While you are enrolled under this *plan*, the following family members, and only the following family members, are also eligible to participate in the *plan*:

- Your legal spouse or qualified domestic partner. The *Plan Sponsor* may require documentation proving a legal marital relationship, an Affidavit of Domestic Partnership or a Certificate of Qualified domestic partner ship.
- Your, your spouse's, or your qualified domestic partner's dependent children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your siblings, nieces, nephews, or grandchildren. A child of an eligible dependent enrolled on your plan under age 19 who is unmarried, not in a domestic partnership, registered or otherwise, who is related to you by blood, marriage, or domestic partnership AND for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- A child placed for adoption with you, your spouse, or qualified domestic partner. Placed for adoption means the assumption and retention by you, your spouse, or qualified domestic partner of a legal obligation for total or partial support of a child in anticipation of adoption or placement for adoption. Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.
- Dependent children' means any natural, step, or adopted children as well as any child placed for adoption with you or your domestic partner are legally obligated to support or contribute support for. It may also include any siblings, nieces, nephews, or grandchildren under age 19 who are unmarried and expected to live in your household for at least a year, if you are the court appointed legal custodian or guardian.

No family or household members other than those listed above are eligible to enroll under your coverage.

Special Rules for Eligibility – At any time, the *Plan Administrator* may require proof that a person qualifies or continues to qualify as a dependent as defined by this *plan*.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

The 'initial enrollment period' is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

When you satisfy your *Plan Sponsor's* probationary waiting period at the hours required for eligibility and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you may be subject to a waiting period. (For more information, see 'Special Enrollment Periods' and 'Late Enrollment' under the Enrolling After the Initial Enrollment Period section.) To enroll, you must complete and sign an enrollment application, which is available from your *Plan Sponsor*. The application must include complete information on yourself and your enrolling family members. Return the application to your *Plan Sponsor*, and your *Plan Sponsor* will send it to PacificSource.

Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your *Plan Sponsor's* probationary waiting period. The probationary waiting period is stated in your Medical Benefit Summary. Coverage will only begin if *Your Plan Sponsor* receives your enrollment application and premium.

Newborns

Your, your spouse's, or your domestic partner's natural born baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. PacificSource cannot enroll the child and pay benefits until your *Plan Sponsor* receives an enrollment application listing the child as your dependent. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. Anytime there is a delay in providing enrollment information, your *Plan Sponsor* may ask for legal documentation to confirm validity.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement for adoption. 'Placement for adoption' means the assumption and retention by you, your spouse, or your domestic partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent. You may be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

If additional premium is required, then the natural born or adopted child's eligibility for enrollment will end 31 days after placement if Plan Sponsor has not received an enrollment application and premium. Premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the natural born or adopted child's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until your Plan Sponsor receives an enrollment application listing the child as your dependent.

Family Members Acquired by Marriage

If you marry, you may add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. Your *Plan Sponsor* must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the marriage. You may be required to submit a copy of your marriage certificate to complete enrollment.

Family Members Acquired by Domestic Partnership

If you and your same-gender domestic partner have been issued a Certificate of Qualified domestic partner ship, your domestic partner and your partner's dependent children are eligible for coverage during the 31-day initial enrollment period after the registration of the domestic partnership. Your *Plan Sponsor* must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the registration of the domestic partnership. You may be required to submit a copy of your Certificate of Qualified domestic partner ship to complete enrollment.

Unregistered same-gender domestic partners and their children may also become eligible for enrollment. If you and your unqualified domestic partner meet the criteria on the Affidavit of Domestic Partnership supplied by your *Plan Sponsor*, your domestic partner and your partner's dependent children are eligible for coverage during the 31-day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. Your *Plan Sponsor* must receive your enrollment application, a notarized copy of your Affidavit of Domestic Partnership, and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the Affidavit of Domestic Partnership is notarized.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you may add that family member to your coverage. To be eligible for coverage, the family member must be:

- Unmarried;
- Not in a domestic partnership, registered or otherwise;
- Related to you by blood, marriage, or domestic partnership
- Under age 19; and
- Expected to live in your household for at least a year.

Your *Plan Sponsor* must receive your enrollment application and additional premium during the 31-day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the date of the court order. You may be required to submit a copy of the court order to complete enrollment.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement that provides for health benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse or child, they may enroll in this plan within the 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after *Plan Sponsor* receives the enrollment application. You may be required to submit a copy of the QMCSO to complete enrollment.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

*If you are laid off and then rehired by your Plan Sponsor within six months, you will not have to satisfy another probationary waiting period or new exclusion period***.**

Your health coverage will resume the day you return to work and again meet your *Plan Sponsor's* minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after an employer-approved leave of absence of three months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume the day you return to work and again meet your *Plan Sponsor's* minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after Family Medical Leave

Your *Plan Sponsor* is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask your health plan administrator. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another probationary waiting period or any previously satisfied exclusion period under this plan. Your health coverage will resume the day you return to work and meet your *Plan Sponsor's* minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at that time if you re-enroll them within the 31-day initial enrollment period following your return.

Status Change

If you are a part-time employee who has declined coverage, you may enroll if you move to full-time status by submitting an enrollment application within 31 days of the change. Coverage is effective the first of the month following the status change. Full-time employees must enroll during their initial enrollment period.

Special Enrollment Periods

If you are eligible to decline coverage and you wish to do so, you must submit a written waiver of coverage to your *Plan Sponsor*. You and your family members may enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below.

- Special Enrollment Rule #1 – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the *Plan Sponsor*'s minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

- Special Enrollment Rule #2 – If you acquire new dependents because of marriage, qualification of domestic partner ship, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired eligible dependents at that time. To do so, you must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

- Special Enrollment Rule #3 – If you or your dependents become eligible for a premium assistance subsidy under Medicare or CHIP, you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's anniversary date.

A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the 31-day initial enrollment period; or

- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by submitting an enrollment application to your *Plan Sponsor* during an open enrollment period designated by your *Plan Sponsor* just prior to the plan's anniversary date. When you or your dependents enroll during the open enrollment period, plan coverage begins on the date *Plan Sponsor* receives the enrollment application or on the plan's anniversary date.

Member ID Card

The membership card issued to you by PacificSource is for identification purposes only. Possession of a membership card confers no right to services or benefits under this plan and misuse of your membership card may be grounds for termination of your coverage under this plan. To be eligible for services or benefits under this plan, you must be an eligible and enrolled in the plan and you must present the membership card to your *health care provider*. If you receive services or benefits for which you are not entitled to receive under the terms of this plan, you may be charged for such services or benefits at the prevailing rate. If you permit the use of your membership card by any other person, your card may be retained by this plan, and all your rights under this plan may be terminated.

PLAN SELECTION PERIOD

If your *Plan Sponsor* offers more than one benefit plan option, you may choose another plan option only upon your plan's anniversary date. You may select a different plan option by completing a selection form or application form. Coverage under the new plan option becomes effective on your plan's anniversary date.

TERMINATING COVERAGE

If you leave your job for any reason or your work hours are reduced below your *Plan Sponsor's* minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this Summary Plan Description for more information.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing a Termination of Dependent Coverage form and submitting it to your *Plan Sponsor*. Keep in mind that once coverage is discontinued, your family members may be subject to the late enrollment waiting period if they wish to re-enroll later.

Divorced Spouses

If you divorce, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your *Plan Sponsor* of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact the PacificSource Membership Services Department. Please see the Continuation section for more information.

Dependent Children

When your enrolled child no longer qualifies as a dependent, coverage will end on the last day of that month. Please see the Eligibility section of this Summary Plan Description for information on when your dependent child is eligible beyond age 25. The Continuation section includes information on other coverage options for those who no longer qualify for coverage.

Dissolution of Domestic Partnership

If you dissolve your domestic partnership, coverage for your domestic partner and their children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify your *Plan Sponsor* of the dissolution of the domestic partnership. Under Oregon state continuation laws, a qualified domestic partner and their covered children may continue this policy's coverage under the same circumstances and to the same extent afforded an enrolled spouse and their enrolled children (see Oregon Continuation in the Continuation of Insurance section. Domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Domestic partners and their covered children may not continue this policy's coverage under COBRA independent of the employee (see COBRA Continuation in the Continuation of Insurance section).

Certificates of Creditable Coverage

A certificate of creditable coverage is used to verify the dates of your prior health plan coverage when you apply for coverage under a new policy. These certificates are issued by health insurers whenever a plan participant's coverage ends. After your or your dependent's coverage under this plan ends, you will receive a certificate of creditable coverage by mail. PacificSource has an automated process that generates and mails these certificates whenever coverage ends. PacificSource will send a separate certificate for any dependents with an effective or termination date that differs from yours. For questions or requests regarding certificates of creditable coverage, you are welcome to contact Membership Services Department at (541) 684-5583 or (866) 999-5583.

CONTINUATION OF INSURANCE

Under federal and state laws, you and your family members may have the right to continue this plan's coverage for a specified time. You and your dependents may be eligible if:

- Your employment ends or you have a reduction in hours
- You take a leave of absence for military service
- You divorce
- You die
- You become eligible for Medicare benefits if it causes a loss of coverage for your dependents
- Your children no longer qualify as dependents

The following sections describe your rights to continuation under state and federal laws, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

You and your enrolled family members may continue this plan's coverage if you, the employee, no longer qualify for coverage under the plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Family members who were not enrolled in the group plan cannot take continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form to your *Plan Sponsor* within 31 days after the last day of coverage under the group plan.
- You must pay continuation premium to your *Plan Sponsor* by the first of each month. Your *Plan Sponsor* will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your *Plan Sponsor* must still be self-insured through PacificSource. If your *Plan Sponsor* discontinues this plan, you will no longer qualify for continuation.

OREGON CONTINUATION

Under this plan, you may have continuation rights under Oregon state law.

Surviving or Divorced Spouses and Qualified Domestic Partners

If your group has 20 or more employees, or your group health plan has 20 or more subscribers, and you die, divorce, or dissolve your qualified domestic partnership, and your spouse or qualified domestic partner is 55 years or older, your spouse or qualified domestic partner may be able to continue coverage until eligible for Medicare or other coverage. Dependent children are subject to the health plan's age and other eligibility requirements. Some restrictions and guidelines apply; please see your *Plan Sponsor* for specific details.

COBRA CONTINUATION

Your *Plan Sponsor* is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask your health plan administrator.

COBRA Eligibility

To be eligible, a *member* must experience a 'qualifying event' which is an event that causes your regular group coverage to end and makes you eligible for continuation coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]
Employer files for Chapter 11 bankruptcy	Only applies to retirees and their covered dependents

[1] If the employee or covered dependent is determined disabled by the Social Security Administration within the first 60 days of continuation coverage, all qualified beneficiaries may continue coverage for up to an additional 11 months, for a total of up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, legal separation, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

If your dependents were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active employees, including the late enrollment waiting period.

If your employment is terminated for gross misconduct, you and your dependents are not eligible for COBRA continuation.

Domestic partners and their covered children may not continue this policy's coverage under COBRA independent of the employee. This plan provides a domestic partner and their dependent children with COBRA-equivalent coverage. Under this COBRA-equivalent coverage, a domestic partner and their dependent children have the same eligibility and maximum continuation periods as a spouse and their dependent children under this plan. Dissolution of a domestic partnership is treated the same as divorce under this plan.

When Continuation Coverage Ends

Your continuation coverage will end before the end of the continuation period above if any of the following occur:

- Your continuation premium is not paid on time.
- You become covered under another group health plan that does not exclude or limit treatment for your pre-existing conditions.

- You become entitled to Medicare benefits.
- Your *Plan Sponsor* discontinues its health plan and no longer offers a group health plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

When COBRA continuation coverage ends, you may be eligible to purchase an individual portability policy. Please see the Individual Portability Policy section for more information.

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If your *Plan Sponsor* provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your *Plan Sponsor* provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as your *Plan Sponsor's* current benefits. Your *Plan Sponsor* has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify your Plan Sponsor within 60 days if you divorce, or if your child no longer qualifies as a dependent. That will allow your Plan Sponsor to notify you or your dependents of your continuation rights.

When your *Plan Sponsor* learns of your eligibility for continuation, your *Plan Sponsor* will notify you of your continuation rights and provide a Continuation Election Form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Election Form to your *Plan Sponsor*. If continuation coverage is not elected during that 60-day period, coverage will end on the last day of the last month you were an active employee.

If you do not provide these notifications within the time frames required by COBRA, *Plan Sponsor*'s responsibility to provide coverage under the health plan will end.

Continuation Premium

You or your family members are responsible for the full cost of continuation coverage. The monthly premium must be paid to your *Plan Sponsor*. PacificSource cannot accept continuation premium directly from you. You may make your first premium payment any time within 45 days after you return your Continuation Election Form to your *Plan Sponsor*. After the first premium payment, each monthly payment must reach your *Plan Sponsor* within 30 days of your *Plan Sponsor's* premium due date. If your *Plan Sponsor* does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the *Plan Sponsor* informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *Plan Sponsor*.

CONTINUATION WHEN YOU RETIRE

If you retire, you and your insured dependents are eligible to continue coverage subject to the following:

- You must apply for continued coverage within 60 days after retirement.
- You must be receiving benefits from PERS (Public Employee Retirement System) or from a similar retirement plan offered by your *Plan Sponsor*.

- If you and/or your enrolled dependents voluntarily terminate retiree coverage under this plan, re-enrollment under this plan will not be possible.

Your continuation coverage will end when any one of the following occurs:

- When full premium is not paid or when your coverage is voluntarily terminated, your coverage will end on the last day of the month for which premium was paid.
- When you become eligible for Medicare coverage, your coverage will end on the last day of the month preceding Medicare eligibility.
- When the regular health plan is terminated, your coverage will end on the date of termination.

Your dependent's continuation coverage will end when any one of the following occurs:

- When full premium for the dependent is not paid or when the dependent's coverage is voluntarily terminated by you or your dependent, coverage will end on the last day of the month for which premium was paid.
- When your dependent becomes eligible for Medicare coverage, your dependent's coverage will end on the last day of the month preceding Medicare eligibility.
- When you die, divorce, or dissolve your domestic partnership, your dependent's coverage will end when your spouse or qualified domestic partner reaches age 65, or in the case of children, when your dependent reaches the normal eligibility termination date.
- When your dependent is otherwise no longer considered a dependent under the group plan, his or her coverage will end on the last day of the month of their eligibility.
- Continuation of coverage may be available under COBRA continuation (see Continuation of Coverage provisions).
- When the regular health plan is terminated, your dependent's coverage will end on the date of termination.

WORK STOPPAGE

Labor Unions

If you are a union member, you have certain continuation rights in the event of a labor strike. Your union is responsible for collecting your premium and can answer questions about coverage during the strike.

EXTENSION OF BENEFITS

If you are on an employer-approved non-FMLA leave of absence, you may continue coverage under active status for up to three months. Absences extending beyond three months will be subject to the Continuation of Insurance provisions of this plan.

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ when you use participating and non participating providers. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred.

All healthcare providers are independent contractors. Neither your *Plan Sponsor* nor PacificSource can be held liable for any claim for damages for injuries you experience while receiving medical care.

PREFERRED PROVIDER ORGANIZATION (PPO)

What is a PPO

A preferred provider organization (PPO) has made agreements with *hospitals*, *physicians*, *practitioners*, and other *health care providers* to discount the cost of services they provide.

Who is Your PPO

The *Plan Sponsor* has chosen PacificSource to provide PPO services for employees and eligible dependents in Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. They also have an agreement with a nationwide provider network, The First Health® Network. The First Health providers outside our service area are also considered *participating providers* under your plan.

A list of *participating provider*s can be accessed through the PacificSource website: psa.pacificsource.com or by calling PacificSource at (888) 532-5332. This list of *participating providers* is updated regularly.

About Your PPO

PacificSource has selected the participating *physician*s, *practitioners*, and *hospital*s after carefully reviewing their qualifications. Each *health care provider* has agreed to a *contracted amount* in payment for their services. Additionally, you cannot be 'balanced billed' for the difference between the PPO *contracted amount* and the provider's normal billed charge for a particular service. You are only responsible for the deductible, *copayment*, and/or *coinsurance* payment shown on the Medical Benefit Summary.

Enrolling in this plan does not guarantee that a particular *participating provider* will remain a *participating provider* or that a particular *participating provider* will provide *members* under this plan only with covered services. *Members* should verify a *health care provider's* status as a *participating provider* each time services are received from the *health care provider*.

It is not safe to assume that when you are treated at a participating medical facility, all services are performed by *participating provider*s. A list of *participating provider*s can be accessed through the PacificSource website: psa.pacificsource.com or by calling PacificSource at (888) 532-5332. Whenever possible, you should arrange for professional services such as surgery and anesthesiology to be provided by a *participating provider*. Doing so will help you maximize your benefits and limit your out-of-pocket expenses. The PPO benefits are outlined on the Medical Benefit Summary.

You have a free choice of any *health care provider*, and the physician-patient relationship shall be maintained. *Members*, together with their *health care provider*, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the plan will pay for all or a portion of the cost of such care. The *participating providers* are merely independent contractors; neither the plan, the *Plan Sponsor*, nor PacificSource makes any warranty as to the quality of care that may be rendered by any *participating provider*.

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from this plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers and/or a list of participating health care professionals who specialize in obstetrics or gynecology, contact PacificSource at (888) 532-5332 or PO Box 70088, Springfield, OR 97475-0105.

Non-PPO Providers

When you receive services or supplies from a *nonparticipating provider*, your out-of-pocket expense is likely to be higher than if you had used a *participating provider*. Besides the non-PPO deductible, *copayment*, and/or *coinsurance* amounts shown on the Medical Benefit Summary, you may become responsible for the provider's billed amount that exceeds the plan's *allowable amount*.

The following illustrates how payment could be made for a covered service billed at $120. This example demonstrates what happens when the benefits for *participating provider*s are paid at 80 percent and the benefits for *nonparticipating provider*s coinsurance of 30 percent. ***This is only an example; your plan's benefits may be different.***

	Participating Provider	***Nonparticipating Provider***
Provider's usual billed charge	$120	$120
PPO's negotiated provider discount	$20	$0
Plan's *allowable amount*	$100	$100
Percent of payment	20%	30%
Plan's payment	$80	$70
Patient's amount of *allowable amount*	$20	$30
Charges above the *allowable amount*	$0	$20
Patient's total payment to provider	$20	$50
Percent of charge paid by plan	80%	58%
Percent of charge paid by patient	20%	42%

Allowable Amount

The plan bases payment to *nonparticipating provider*s on an *allowable amount* for the same services or supplies. Several sources are used to determine the *allowable amount*, depending on the service or supply and the geographical area where it is provided. The *allowable amount* may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, other nationally recognized databases, or PacificSource.

COVERED EXPENSES

This plan provides comprehensive medical coverage when care is medically necessary to treat an illness or injury. Be careful – just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under the terms of the plan. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean all billed charges will be paid.

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section of this book, including the section on Preauthorization. If you ever have a question about your plan benefits, contact the PacificSource Customer Service Department.

Medical Necessity

Except for specified Preventive Care services, the benefits of this health plan are paid only toward the covered expense of medically necessary diagnosis or treatment of illness or injury. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. For additional information, see 'medically necessary' in the Definitions section of this Summary Plan Description.

Be careful. Your healthcare provider could prescribe services or supplies that are not covered under this plan. Also, just because a service or supply is a covered benefit does not mean all related charges will be paid.

Healthcare Providers

This plan provides benefits only for covered expenses and supplies rendered a physician (M.D. or O.D.), practitioner, nurse, hospital or specialized treatment facility, durable medical equipment supplier, or other licensed medical provider as specifically stated in this Summary Plan Description. The services or supplies provided by individuals or companies that are not specified as eligible practitioners are not eligible for reimbursement under the benefits of this plan. For additional information, see 'practitioner', 'specialized treatment facility', and 'durable medical equipment supplier' in the Definitions section of this Summary Plan Description.

Your Annual Deductible

Deductible Carryover. The deductible must be satisfied only once in any calendar year, even though there may be several conditions treated. Covered expenses incurred during the last three (3) months of the previous calendar year will be applied to the subsequent year's calendar year deductible subject to the following:

- The covered expenses were applied to the deductible;
- The covered expenses were incurred during the last three (3) months of the year; and
- The prior year's deductible was not satisfied.

Final determination of which expenses apply to the deductible will be based on the order in which charges are incurred, even if bills for charges are not received in that order.

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows your plan's annual out-of-pocket limits for participating and/or nonparticipating providers. If you incur covered expenses over those amounts, this plan will pay 100 percent of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual out-of-pocket limit:

- Charges applied to deductible, if applicable to your plan
- Copayments, if applicable to your plan
- Prescription drugs
- Charges over the allowable fee for services of nonparticipating providers
- Incurred charges that exceed amounts allowed under this plan

Charges over the allowable fee for services of nonparticipating providers, and incurred charges that exceed amounts allowed under this plan, copayments, and charges not covered by this plan will continue to be your responsibility even after the out-of-pocket or stop-loss limit is reached.

Prescription drug benefits are not affected by the out-of-pocket or stop-loss limit. You will still be responsible for that copayment or coinsurance payment even after the out-of-pocket or stop-loss limit is reached.

MEDICAL BENEFITS

About Your Medical Benefits

All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood.

Medical Necessity – The plan provides benefits only for covered services and supplies that are *medically necessary* for the treatment of a covered *illness* or *injury*. Be careful—just because a treatment is prescribed by a healthcare professional does not necessarily mean it is *medically necessary* as defined by the plan. And, some *medically necessary* services and supplies may be excluded from coverage. Also, the treatment must not be *experimental and/or investigational*.

Allowable Fees – The plan provides benefits only for covered expenses that are equal to or less than the *allowable amount*, as defined by the plan, in the geographic area where services or supplies are provided. Any amounts that exceed the *allowable amount* are not recognized by the plan for any purpose.

Health Care Provider – The plan provides benefits only for covered expenses and supplies rendered by a *physician*, *practitioner*, nurse, *hospital* or *specialized treatment facility*, *durable medical equipment* supplier, or other licensed medical provider as specifically stated in this plan summary. The services or supplies provided by individuals or companies that are not specified as eligible *practitioners* are not eligible for reimbursement under the benefits of this plan. For additional information, see *practitioner*, *specialized treatment facility*, and *durable medical equipment* in the Definitions section of this document.

***Custodial Care* Providers** – The plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medications, academic, social, or behavior skills training, and other services that can be provided by persons without the training of a health care *practitioner*.

Benefit Year – The word year, as used in this document, refers to the *benefit year*, which is the 12-month period beginning January 1 and ending December 31. Unless otherwise specified, all annual benefit maximums and deductibles accumulate during the *benefit year*.

Deductibles – A deductible is the amount of covered expenses you must pay during each year before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the year. The annual individual and family deductible amounts are shown on the Medical Benefit Summary.

Benefit Percentage Payable – Benefit percentage payable represents the portion of covered expenses paid by the plan after you have satisfied any applicable deductible. These percentages apply only to covered expenses which do not exceed the *allowable amount*. You are responsible for all remaining covered and non-covered expenses, including any amount that exceeds the *allowable amount* for covered services. The benefit percentages payable are shown on the Medical Benefit Summary.

Copayments – *Copayment*s are the first-dollar amounts you must pay for certain covered services, which are usually paid at the time the service is performed (i.e. *physician* office visits or emergency room visits). These *copayment*s do not apply to your annual deductible or out-of-pocket maximum, unless otherwise specified on the Medical Benefit Summary. The *copayment* amounts are shown on the Medical Benefit Summary.

Out-Of-Pocket Maximum(s) – An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a year, before the plan's benefit percentage payable increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches the annual out-of-pocket maximum, the plan will pay 100% of additional covered expenses for that individual during the remainder of that year, subject to the *lifetime* maximum amount, if applicable. However, expenses for services which do not apply to the out-of-pocket maximum will never be paid at 100%. The annual individual and family out-of-pocket maximum amounts are shown on the Medical Benefit Summary.

Benefit Maximums – Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount may also apply to a specific time period, such as annual.

Least Costly Setting For Services – Benefits of the plan provide for reimbursement of covered services performed in the least costly setting where services can be safely provided. If a procedure can be done safely in an outpatient setting but is performed in a *hospital* inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits may be reduced.

PLAN BENEFITS

This plan provides benefits for the following services and supplies as outlined on your Medical Benefit Summary. These services and supplies may require you to satisfy a deductible, make a copayment, or both, and they may be subject to additional limitations or maximum dollar amounts. For a medical expense to be eligible for payment, you must be covered under this plan on the date the expense is incurred. Please refer to your Medical Benefit Summary and the Benefit Limitations and Exclusions section of this Summary Plan Description for more information.

PREVENTIVE CARE SERVICES

Any plan deductible, copayment, and/or coinsurance amounts stated in your Medical Benefit Summary are waived for the following recommended preventive care services when provided by a participating provider:

- Services that have a rating of 'A' or 'B' from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

Links to the lists of recommended preventive care and screenings from the USPSTF, CDC, and HRSA can be found at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Current USPSTF recommendations include the September 2002 recommendations regarding breast cancer screening, mammography, and prevention, not the November 2009 recommendations**.**

This plan covers the following preventive care services when provided by a physician, physician assistant, or nurse practitioner:

- **Routine physicals** for members age 22 and older:
  - Ages 22-34: One exam every four years
  - Ages 35-59: One exam every two years
  - Ages 60 and over: One exam every year

  Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventative care benefit. Please see Outpatient Services in this section.

- **Well woman visits**, including the following:
  - One **routine gynecological exam** each benefit year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
  - **Routine preventive mammograms** for women as recommended.
    - The deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for 'Preventive Care – Well Woman Visits' applies to mammograms that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
    - The deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for 'Outpatient Services – Diagnostic and Therapeutic Radiology and Lab 'applies to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.
  - **Pelvic exams and Pap smear exams** at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider.
  - **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.

- **Colorectal cancer screening** exams and lab work including the following:

- **A fecal occult blood test**
- **A flexible sigmoidoscopy**
- **A colonoscopy**
  - A colonoscopy performed for routine screening purposes is considered to be a preventive service. The deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for 'Preventive Care – Routine Colonoscopy' applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force for age 50 through 75.
  - A colonoscopy performed for evaluation or treatment of a known medical condition is considered to be Outpatient Surgery. The deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for 'Professional Services – Surgery' and for Outpatient Services – Outpatient Surgery/Services' apply to colonoscopies related to ongoing evaluation or treatment of a medical condition.
- A double contrast barium enema

- **Prostate cancer screening**, including a digital rectal examination and a prostate-specific antigen test.
- **Well baby/well child care exams** for members age 21 and younger according to the following schedule:
  - At birth: One standard in-hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per year

  Only laboratory tests and other diagnostic testing procedures related to a well baby/well child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/well child care exam are not covered by this preventative care benefit. Please see Outpatient Services in this section.
- Standard age-appropriated childhood and adult **immunizations** for primary prevention of infectious diseases as recommended by and adopted the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include, but may not be limited to the following:
  - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine
  - Hepatitis B vaccine
  - Human papillomavirus (HPV) vaccine
  - Influenza virus vaccine
  - Measles, mumps, and rubella (MMR) vaccines, given separately or together
  - Meningococcal (meningitis) vaccine
  - Pneumococcal vaccine
  - Polio vaccine
  - Varicella (chicken pox) vaccine

- **Tobacco use cessation program services** are covered only when provided by a PacificSource approved program. Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older. Specific nicotine replacement therapy will only be covered according to the program's description. If this policy includes benefits for prescription drugs, tobacco use cessation related medication prescribed in conjunction with an approved tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician (M.D. or D.O.)** for diagnosis or treatment of illness or injury

- Services of a licensed **physician assistant** under the supervision of a physician

- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery

- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury

- **Urgent care services** provided by a physician. Urgent care is unscheduled medical care for an illness, injury, or disease that a prudent lay person would consider not life-threatening and treatable at urgent care. Examples of urgent care situations include sprains, cuts, and illnesses that do not require immediate medical attention in order to prevent seriously damaging the health of the person.

- **Outpatient rehabilitative services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitative services is limited to a maximum of 30 visits per benefit year subject to review by PacificSource for medical necessity. Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.

  Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses and injuries are covered up to one year post injury when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists.

  Outpatient pulmonary rehabilitation programs are covered when prescribed by a physician for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.

  For related provisions, see 'motion analysis', 'vocational rehabilitation', and 'speech therapy' under 'Excluded Services – Types of Treatments' in the Benefit Limitations and Exclusions section of this Summary Plan Description.

- **Outpatient habilitation services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for habilitation services are limited to a maximum of 30 visits for outpatient services per calendar year. Habilitation services are subject to review by PacificSource for medical necessity. Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which habilitation services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits or days per condition, when criteria for supplemental services are met.

- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

  Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Their staff will explain your plan's maternity benefits and help you enroll in our free prenatal care program.

- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in this plan.

- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.

- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 18 months of the injury. Except for the initial examination, services for treatment of an injury to the jaw or natural teeth require preauthorization to be covered.

- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:

  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident.

  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery.

- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease

- Medically necessary **telemedical health services** for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

- Treatment of **temporomandibular joint syndrome (TMJ)** for medical reasons only. All TMJ-related services, including but not limited to diagnostic and surgical procedures, must be preauthorized by PacificSource. Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are limited to 50 percent of eligible charges.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

This plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation. Coverage includes **eligible services** provided by a hospital owned or operated by the state of Oregon, or any state approved mental health and developmental disabilities program.

In addition to the hospital room, covered inpatient hospital services may include (but are not limited to):

- Cardiac care unit

- Operating room

- Anesthesia and post-anesthesia recovery

- Respiratory care

- Inpatient medications

- Lab and radiology services

- Dressings, equipment, and other necessary supplies

The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

Services of a **skilled nursing facility and convalescent homes** are covered for up to 60 days per benefit year when preauthorized by PacificSource. Services must be medically necessary. Confinement for custodial care is not covered.

Inpatient rehabilitative services medically necessary to restore and improve lost body functions after illness or injury. The service must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician. This benefit is limited to a maximum of 30 days per benefit year, except that treatment for head or spinal cord injuries is covered for up to 60 days per benefit year. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- **Advanced diagnostic imaging procedures** that are medically necessary for the diagnosis of illness or injury. For purposes of this benefit, advanced diagnostic imaging procedures include CT scans, MRIs, PET scans, CATH labs and nuclear cardiology studies. When services are provided as part of a covered emergency room visit, your plan's emergency room benefit applies. In all other situations and settings, benefits are subject to the deductibles, copayments, and/or coinsurance stated in your Medical Benefit Summary for Outpatient Services – Advanced Diagnostic Imaging.

- Diagnostic **radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, alternative care practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.

- Benefits for members who are receiving services for end-stage renal disease (ESRD) who are eligible for Medicare, are limited to 125% of the current Medicare allowable amount for participating and nonparticipating ESRD service providers. Benefits will continue to be paid at the cost share level applied to other benefits in the same category for members who are not eligible for Medicare.

- **Emergency room services**. The emergency room copayment stated in your Medical Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The copayment does not cover further treatment provided on referral from the emergency room.

  In true medical emergencies, nonparticipating providers are paid at the participating provider level.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. That includes conditions subject to the plan's exclusion periods. Please see the Benefit Limitations and Exclusions section of this Summary Plan Description.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services – Office Procedures and Supplies applies.
  - For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits stated in your Medical Benefit Summary for Professional Services – Surgery and the Outpatient Services Outpatient Surgery/Services apply.

- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

- Other medically necessary **diagnostic services** provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition.

EMERGENCY SERVICES

In a true medical emergency, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient. An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to):

- Unusual or heavy bleeding
- Sudden abdominal or chest pains
- Suspected heart attacks
- Major traumatic injuries
- Serious burns
- Poisoning
- Unconsciousness
- Convulsions or seizures
- Difficulty breathing
- Sudden fevers

If you need immediate assistance for a medical emergency, call 911. *If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility. Care for a medical emergency is covered at the participating provider percentage stated in your Medical Benefit Summary even if you are treated at a nonparticipating hospital.*

If you are admitted to a nonparticipating hospital after your emergency condition is stabilized, *Plan Sponsor* may require you to transfer to a participating facility in order to continue receiving benefits at the participating provider level.

MATERNITY SERVICES

Maternity means, in any one pregnancy, all prenatal services including complications and miscarriage, delivery, postnatal services provided within six months of delivery, and routine nursery care of a newborn child. Maternity services are covered subject to the deductible, co-payments, and/or co-insurance stated in your Medical Benefit Summary regardless of marital status.

Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Our staff will explain your plan's maternity benefits and help you enroll in our free prenatal care program.

This plan provides **routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in this plan, regardless of marital status.

Special Information about Childbirth – PacificSource covers hospital inpatient services for childbirth according to the Newborns' and Mothers' Health Protection Act of 1996. This plan does not restrict the length of stay for the mother or newborn child to less than 48 hours after vaginal delivery, or to less than 96 hours after Cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. For childbirth, your provider does not need to preauthorize your hospital stay with PacificSource.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency. Refer to the Benefit Limitations and Exclusions section of this Summary Plan Description for more information on services not covered by your plan.

Mental Health and Chemical Dependency Services

It is the intent of this plan to comply with all existing regulations of Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). If for some reason the information presented in the plan differs from the actual regulations of the MHPAEA, the plan reserves the right to administer the plan in accordance with such actual regulations.

Providers Eligible for Reimbursement

A mental and/or chemical healthcare provider (see Definitions section of this Summary Plan Description) is eligible for reimbursement if:

- The mental and/or chemical healthcare provider is approved by the Oregon Department of Human Services;
- The mental and/or chemical healthcare provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities; and
- The patient is staying overnight at the mental and/or chemical healthcare facility (see Definitions section of this Summary Plan Description) and is involved in a structured program at least eight hours per day, five days per week; and
- The mental and/or chemical healthcare provider is providing a covered benefit under this policy.

Eligible mental and/or chemical healthcare providers are:

- A program licensed, approved, established, maintained, contracted with, or operated by the Addictions and Mental Health Division of the Oregon Health Authority;
- A medical or osteopathic physician licensed by the State Board of Medical Examiners;
- A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- A nurse practitioner registered by the State Board of Nursing;
- A clinical social worker (L.C.S.W.) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (L.P.C.) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (L.M.F.T.) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- A hospital or other healthcare facility licensed by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. PacificSource will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity.
- A second opinion may be required for a medical necessity determination. PacificSource will notify the patient when this requirement is applicable.
- PacificSource must be notified of an emergency admission within two business days.

- Medication management by an M.D. (such as a psychiatrist) does not require review.
- Treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine.

Mental Health Parity and Addiction Equity Act of 2008

This group health plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008.

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource. Covered services include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage stated in your Medical Benefit Summary for home health care.
- This plan covers **hospice services** when preauthorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative or friend, or private duty nursing. PacificSource uses the following criteria to determine eligibility for hospice benefits:
  - The member's physician must certify that the member is terminally ill with a life expectancy of less than six months;
  - The member must be living at home;
  - A non-salaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and
  - The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

  Only the following hospice services are covered:

  - Home nursing visits.
  - Home health aides when necessary to assist in personal care.
  - Home visits by a medical social worker.
  - Home visits by the hospice physician.
  - Prescription medications for the relief of symptoms manifested by the terminal illness.
  - Medically necessary physical, occupational, and speech therapy provided in the home.
  - Home infusion therapy.
  - Durable medical equipment, oxygen, and medical supplies.
  - Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.
  - Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary.
  - Pastoral care and bereavement services.

The member retains the right to all other services provided under this contract, including active treatment of non-terminal illnesses, except for services of another provider that duplicate the services of the hospice team.

DURABLE MEDICAL EQUIPMENT

- This plan covers **prosthetic and orthotic devices** that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see the Benefit Limitations and Exclusions section for information on items not covered. The following limitations apply to durable medical equipment:

  - This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the plan. If the cost of the purchase, rental, repair, or replacement is over $800, preauthorization by PacificSource is required.

  - Only expenses for durable medical equipment, or prosthetic and orthotic devices that are provided by a PacificSource contracted provider or a provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement. Mail order or Internet/Web based providers are not eligible providers.

  - Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires preauthorization by PacificSource and is payable only in lieu of benefits for a manual wheelchair. For members age 19 or older, this benefit is limited to one power-assisted wheelchair in a lifetime.

  - The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to the following limitations:

    - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.

    - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to $200 per initial case. 'Initial case' is defined as the first time surgery or treatment is performed on either eye. Other policy limitations, such as exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.

    - Benefits for subsequent medically necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.

    - Reimbursement is subject to the deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for durable medical equipment and is in lieu of, and not in addition to benefits payable under any vision endorsement that may be added to this plan.

- The durable medical equipment benefit also covers hearing aids for members 18 years of age and younger, or 25 years of age and younger if the member is enrolled in a secondary school or an accredited educational institution. Coverage is limited to a maximum benefit of $4,000 every 48 months. The benefit amount may be adjusted on January 1 of each year to reflect the U.S. City Average Consumer Price Index.

- Medically necessary treatment for sleep apnea and other sleeping disorders is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.

- Wigs following chemotherapy or radiation therapy are covered up to a maximum benefit of $150 per benefit year.

- Breastfeeding pumps, manual and electric, are covered at no cost per pregnancy when purchased or rented from a licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are excluded under preventive care and regular benefits.

TRANSPLANT SERVICES

This plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

All pretransplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization by PacificSource.

You must have been covered under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. See Exclusion Periods – Transplants in the Benefit Limitations and Exclusions section of this Summary Plan Description for details.

This plan covers the following medically necessary organ and tissue transplants:

- Kidney
- Kidney – Pancreas
- Pancreas whole organ transplantation (under certain criteria)
- Heart
- Heart – Lung
- Lung
- Liver (under certain criteria)
- Bone marrow and peripheral blood stem cell
- Pediatric bowel

This plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.

Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations:

- Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient.
- Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same maximum dollar limitation, if any, as the transplant itself.

- Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is at the same percentage payable for the transplant itself, and applies to the maximum dollar limitation for the transplant, if any.

  - If the donor is not a PacificSource member, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only to the extent that they are not covered by another health plan or government program. Coverage is at the same percentage payable for the transplant itself, and also applies to the maximum dollar limitation, if any, for the transplant.

  - If the donor is a PacificSource member, complications of the donation are covered as any other illness would be covered.

- Transplant related services, including HLA typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's provider contractual agreements (see Payment of Transplant Benefits, below).

Travel and housing expenses for the recipient and one caregiver are limited to $5,000 per transplant. Travel and living expenses are not covered for the donor.

Payment of Transplant Benefits

If a transplant is performed at a participating Center of Excellence transplantation facility, covered charges of the facility are covered in full. If PacificSource's contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also covered in full. If the professional fees are not included in PacificSource's contract with the facility, then those benefits are provided according to your Medical Benefit Summary.

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any deductibles or copayments stated in your Medical Benefit Summary. This plan then pays either 70 percent of the billed amount or $100,000, whichever is less. Services of nonparticipating medical professionals are paid at the nonparticipating provider percentages stated in your Medical Benefit Summary.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Reimbursement to nonparticipating air ambulance services are based on 125% of the Medicare allowance. In some cases Medicare allowance may be significantly lower than the provider's billed amount. The provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable deductibles and coinsurance. Medically necessary travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition is covered when approved in advance by PacificSource.

- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions.

- This plan covers **blood transfusions**, including the cost of blood or blood plasma.

- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery.

  - Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

- PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit.

- This plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient for:

  - All stages of reconstruction of the breast on which the mastectomy was performed;

  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;

  - Prostheses; and

  - Treatment of physical complications of the mastectomy, including lymphedema

  Benefits for breast reconstruction are subject to all terms and provisions of the plan, including deductibles, copayments and/or coinsurance stated in your Medical Benefit Summary.

- This plan covers **cardiac rehabilitation** as follows:

  - Phase I (inpatient) services are covered under inpatient hospital benefits.

  - Phase II (short-term outpatient) services are covered subject to the deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.

  - Phase III (long-term outpatient) services are not covered.

- This plan covers IUD, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms are not covered.

- This plan covers **corneal transplants**. Preauthorization is not required.

- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**

  - When necessary to correct a functional disorder; or

  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or

  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

  Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see ‘breast prosthesis’ and ‘breast reconstruction’ in this section.

- This plan covers dental and orthodontic services for the treatment of **craniofacial anomalies** when medically necessary to restore function. Coverage includes but is not limited to physical disorders identifiable at birth that affect the bony structures of the face or head, such as cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. See the exclusions for cosmetic/reconstructive services, dental examinations and treatment, jaw surgery, and orthognathic surgery under the ‘Excluded Services’ section

- This plan provides coverage for certain **diabetic supplies and training** as follows:

  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.

- Diabetic insulin and syringes are covered under your prescription drug benefit. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.
- This plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.
- This plan covers medically necessary telemedical health services provided in connection with the treatment of diabetes (see Professional Services in this section).

- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits).

- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for durable medical equipment.

- This plan covers routine **foot care** for patients with diabetes mellitus.

- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.

- This plan covers treatment for **inborn errors of metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subject to the deductible, copayment, and/or coinsurance stated in your Medical Benefit Summary for durable medical equipment.

- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.

- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures and artificial larynx are also not covered.

- For **pediatric dental care** requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to a lifetime maximum of $1,000 and preauthorization by PacificSource is required.

- The **routine costs of care associated with approved clinical trials** are covered. Benefits are only provided for routine costs of care associated with approved clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. For more information, see 'routine costs of care' in the Definitions section of this handbook. A 'qualified individual' is someone who is eligible to participate in a qualifying clinical trial. If a participating provider is participating in an approved clinical trial, the qualified individual may be required to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.

- **Scheduled and/or non-emergent medical care outside of the United States** is covered for covered employees residing outside the United States for three or more months as part of their job requirements, and for full-time students attending college outside the United States for three or more months.

- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.

- This plan covers medically necessary therapy and services for the treatment of **traumatic brain injury.**

- This plan covers **tubal ligation and vasectomy** procedures.

- **Prosthesis for organic impotency** is covered when preauthorized by PacificSource, up to a lifetime maximum of $4,000. The lifetime maximum includes all services and supplies related to placement and follow-up care, including replacement and reoperation but excluding any medical complications related to the procedure.

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits can be reduced by up to 30 percent or $2,500, whichever is less.

EXCLUDED SERVICES

Types of Treatment – This plan does not cover the following:

- Abdominoplasty for any indication

- Academic skills training

- Admission prior to coverage – Services and supplies for an admission to a hospital, skilled nursing facility or specialized facility that began before the patient's coverage under this plan

- Any amounts in excess of the allowable fee for a given service or supply

- Aversion therapy

- Benefits not stated – Services and supplies not specifically described as benefits under the group health policy and/or any endorsement attached hereto

- Biofeedback (other than as specifically noted under the Covered Expenses – Other covered Services, Supplies, and Treatment section)

- Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, and preparation of meals, homemaker services, special diets, rest crew, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this policy's hospice benefit (see Covered Expenses – Hospital, Skilled Nursing Facility, Home Health, and Hospice Services).

- Charges for inpatient stays that begin before you were covered by this plan

- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims

- Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply

- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)

- Chelation therapy including associated infusions of vitamins and/or minerals, except as medically necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data

- Cosmetic/reconstructive services and supplies – Except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section of this handbook, services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered cosmetic/reconstructive surgery. Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, regardless of whether the area to be treated is normal or abnormal.

- Court-ordered sex offender treatment programs

- Court-ordered screening interviews or drug or alcohol treatment programs

- Criminal conduct – Illness or injury in which a contributing cause was the member's commission of or attempt to commit a felony, including illness or injury in which a contributing cause was being engaged in an illegal occupation

- Day care or custodial care – Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, preparation of meals, homemaker services, special diets, rest cures, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this plan's hospice benefit. For related provisions, see 'Hospital and Skilled Nursing Facility Services' and 'Home Health and Hospice Services' in the Covered Expenses section of this handbook.

- Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Forth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger

- Drugs and biologicals that can be self administered (including injectibles), other than those provided in a hospital emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered

- Drugs or medications not prescribed for inborn errors of metabolism, diabetic insulin, or autism spectrum disorder that can be self-administered (including prescription drugs, injectable drugs, and biologicals), unless given during a visit for outpatient chemotherapy or dialysis or during a medically necessary hospital, emergency room or other institutional stay.

- Educational or correctional services or sheltered living provided by a school or halfway house

- Electronic Beam Tomography (EBT)

- Equine/animal therapy

- Equipment commonly used for nonmedical purposes – This plan does not cover the following:

  — Equipment commonly used for nonmedical purposes, or marketed to the general public, or intended to alter the physical environment. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.

  — Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition

- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems

- Experimental or investigational procedures – Your PacificSource plan does not cover experimental or investigational treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered: Has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing; Is not of generally accepted medical practice in Oregon or as determined by medical advisors, medical associations, and/or technology resources; Is not approved for reimbursement by the Centers for Medicare and Medicaid Services; Is furnished in connection with medical or other research; or Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

  An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by your healthcare provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

  When making benefit determinations about whether treatments are investigational or experimental, we rely on the above resources as well as: Expert opinions of specialists and other medical authorities; Published articles in peer-reviewed medical literature; External agencies whose role is the evaluation of new technologies and drugs; and External review by an independent review organization.

  The following will be considered in making the determination whether the service is in an experimental and/or investigational status: Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes; Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives; Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and Whether any improved health outcomes from the services are attainable outside an investigational setting.

  If you or your provider has any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service Department. We will arrange for medical review of your case against our criteria, and notify you of whether the proposed treatment will be covered.

- Eye exercises, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors

- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error except as indicated in the Covered Services section of this handbook

- Family planning – Services and supplies for artificial insemination, in vitro fertilization, treatment of infertility, erectile dysfunction, frigidity, or surgery to reverse voluntary sterilization. For related provisions, see the exclusion for 'infertility' in this section.

- Fitness or exercise programs and health or fitness club memberships

- Food dependencies

- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy or hyperplasia of the skin of the feet, and other routine foot care, except in the case of patients being treated for diabetes mellitus

- Genetic (DNA) testing – DNA and other genetic tests, except for those tests identified as medically necessary for the diagnosis and standard treatment of specific diseases

- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies

- Hearing Aids for individuals 19 and over, including the fitting, provision or replacement of hearing aids
- Homeopathic treatment
- Hypnotherapy
- Immunizations when recommended for or in anticipation of exposure through travel or work
- Infertility – Services and supplies, surgery, treatment, or prescriptions to prevent, or cure infertility or to induce fertility (including Gamete and/or Zygote Interfallopian Transfer; i.e. GIFT or ZIFT), except for medically necessary medication to preserve fertility during treatment with cytotoxic chemotherapy. For related provisions, see the exclusion for 'family planning' in this section. For purposes of this plan, infertility is defined as:
  - Male: Low sperm counts or the inability to fertilize an egg
  - Female: The inability to conceive or carry a pregnancy to 12 weeks
- Instructional or educational programs, except diabetes self-management programs or as listed under 'Preventive Care Services'
- Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Learning disorders
- Marital/partner counseling
- Massage, massage therapy or neuromuscular re-education, even as part of a physical therapy program
- Mental illness does not include – Treatment of intellectual disabilities; learning disorders; paraphilias; and relationship problems (e.g. parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse of a child, neglect of a child, or bereavement. This plan does not cover educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter; psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; a court-ordered sex offender treatment program; a court-ordered screening interview or drug or alcohol treatment program; or nicotine related disorders.

  The following treatment types are also excluded, regardless of diagnosis: marital/partner counseling; support groups; sensory integration training; biofeedback except to treat migraine headaches or urinary incontinence; hypnotherapy; academic skills training; narcosynthesis; aversion therapy; and social skill training. Recreation therapy is only covered as part of an inpatient or residential admission.

  The following are also excluded: court-mandated diversion and/or chemical dependency education classes; court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous; adolescent wilderness treatment programs; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a stress management, parenting skills, or family education; assertiveness training; image therapy; sensory movement group therapy; marathon group therapy; sensitivity training; and psychological evaluation for sexual dysfunction or inadequacy.
- Mental retardation for individuals 18 years of age or older
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this plan. For related provisions, see 'Transplant Services' in the Covered Expenses section of this handbook.

- Narcosynthesis
- Nicotine related disorders
- Obesity or weight control – Surgery or other related services or supplies provided for weight control or obesity (including all categories of obesity) except as listed under 'Preventive Care Services', whether or not there are other medical conditions related to or caused by obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, regardless of the medical conditions that may be caused or exacerbated by excess weight, and self-help or training programs for weight control. Obesity screening and counseling are covered for children and adults; see the 'dietary or nutritional counseling' section under 'Other Covered Services'.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified under 'Professional Services' in the Covered Expenses section of this handbook.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Over-the-counter medications or nonprescription drugs
- Panniculectomy for any indication
- Paraphilias
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self administer drugs or nutrition (except for diabetic education benefit)
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present
- Recreation therapy
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and training programs
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charges under warranty or other agreement
- Routine services and supplies – Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, cosmetic purpose, environmental control, or education of a patient or for the processing of records or claims. These include but are not limited to:
- Missed appointments, completion of claim forms, or reports requested by PacificSource in order to process claims
  - Appliances, such as air conditioners, humidifiers, air filters, whirlpools, hot tubs, heat lamps, or tanning lights
  - Private nursing services or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility
  - Maintenance supplies and equipment not unique to medical care
- Scheduled and/or non-emergent medical care outside of the United States

- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including but not limited to total body CT imaging, CT colonography and bone density testing). This does not include preventive care screenings listed under 'Preventive Care Services' in the Covered Expenses section of this handbook.

- Self-help or training programs

- Sensory integration training

- Services of providers who are not eligible for reimbursement under this plan. An individual organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. And to the extent PacificSource maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.

- Services or supplies available to you from another source, including those available through a government agency

- Services or supplies for which no charge is made, for which the member is not legally required to pay, or for which a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes services provided by the member, or by an immediate family member.

- Services or supplies for which you are not willing to release the medical or eligibility information PacificSource needs to determine the benefits paid under this plan

- Services or supplies received after enrollment in this policy ends. The only exception is if this policy is replaced by another group health policy while you are hospitalized. The will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.

- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.

- Services otherwise available – These include but are not limited to:

  — Services or supplies for which payment could be obtained in whole or in part if the member applied for payment under any city, county, state (except Medicaid), or federal law; and

  — Services or supplies the member could have received in a hospital or program operated by a federal government agency or authority, except otherwise covered expenses for services or supplies furnished to a member by the Veterans' Administration of the United States that are not military service-related.

  This exclusion does not apply to covered services provided through Medicaid or by any hospital owned or operated by the State of Oregon or any state-approved community mental health and developmental disability program.

- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy unless medically necessary to treat a mental health issue and diagnosis. For related provisions, see the exclusions for 'family planning', 'infertility', and 'mental illness' in this section.

- Sex reassignment – Procedures, services or supplies related to a sex reassignment unless medically necessary. For related provisions, see exclusions for 'mental illness' in this section.

- Excluded procedures include, but are not limited to: staged gender reassignment surgery, including breast augmentation; penile implantation; liposuction, thyroid chondroplasty, laryngoplasty, or shortening of the vocal cords, and/or hair removal specifically to assist the appearance of other characteristics of gender reassignment.

- Snoring – Services or supplies for the diagnosis or treatment of snoring and/or upper airway resistance disorders, including somnoplasty

- Social skill training

- Speech therapy – Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years of age or younger diagnosed with a pervasive developmental disorder.

- Support groups

- Surgery to reverse voluntary sterilization

- Training or self-help programs – General fitness exercise programs, and programs that teach a person how to use durable medical equipment or care for a family member. Also excluded are health or fitness club services or memberships and instruction programs, including but not limited to those to learn to self-administer drugs or nutrition, except as specifically provided for in this plan.

- Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this plan for covered transplantation expenses. For related provisions see 'Transplant Services' in the Covered Expenses section of this handbook.

- Treatment after insurance ends – Services or supplies a member receives after the member's coverage under this plan ends

- Treatment of any illness, injury, or disease resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority

- Treatment of any work-related illness, injury, or disease, unless you are the owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance. This includes illness, injury, or disease caused by any for-profit activity, whether through employment or self employment.

- Treatment not medically necessary – Services or supplies that are not medically necessary for the diagnosis or treatment of an illness, injury, or disease. For related provisions, see 'medically necessary' in the Definitions section and 'Understanding Medical Necessity' in the Covered Expenses section of this handbook.

- Treatment prior to enrollment – Services or supplies a member received prior to enrolling in coverage provided by this plan

- Treatment while incarcerated – Services or supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

- Unwilling to release information – Charges for services or supplies for which a member is unwilling to release medical or eligibility information necessary to determine the benefits payable under this plan

- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years or younger diagnosed with a pervasive development disorder.

- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces

- Work-related conditions – Services or supplies for treatment of illness, injury, or disease arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation, except in the case of owners, partners, or principles injured in the course of employment of the employer/policyholder and who are otherwise exempt from, and not covered by, state or federal workers' compensation insurance.

Exclusion Period for Transplant Benefits

- Except for corneal transplants, organ and tissue transplants are not covered until you have been enrolled in this plan for 24 months or since birth. If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for your prior coverage. See the Credit for Prior Coverage section, below.

CREDIT FOR PRIOR COVERAGE

You can receive credit toward this plan's exclusion periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your Plan Sponsor's probationary waiting period) under this plan.

Your prior coverage must have been a group health plan, COBRA or state continuation coverage, individual health policy (including student plans), Medicare, Medicaid, TRICARE, State Children's Health Insurance Program, coverage through high risk pools or the Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show you had creditable coverage. If you qualify for credit, PacificSource will count every day of coverage under your prior plan toward this plan's exclusion period for transplants (explained above).

Evidence of Prior Creditable Coverage

You can show evidence of creditable coverage by sending PacificSource a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request. Most insurers issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or *Plan Sponsor* (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, contact PacificSource's Membership Services Department for assistance.

HEALTH CARE MANAGEMENT AND PREAUTHORIZATION

What is Health Care Management

Your *Plan Sponsor* desires to provide you and your family with a heath care benefit plan that financially protects you from significant health care expenses and assures you quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a high percentage of the cost for health care services may be unnecessary. For example, *hospital* stays may be longer than necessary. Some hospitalizations may be entirely avoidable, such as when surgery could be performed at an outpatient facility with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. All of these instances increase costs for you and the plan.

Your *Plan Sponsor* has contracted with PacificSource to assist you in determining whether or not proposed services are appropriate for reimbursement under this plan. The program is not intended to diagnose or treat medical conditions, dictate a treatment plan, guarantee benefits, or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness for reimbursement of *hospital* stays and proposed *surgical procedure*s.

Required Admission Review – You are required to call PacificSource' toll-free number, (888) 532-5332, prior to any *elective* inpatient stay or any scheduled *surgical procedure*. In most cases, your medical provider will make the call for you. You must also call within 48 hours of any emergency admission. When you or your provider call, it will be necessary to provide the program with your name, the patient's name, the name of the *physician* or *practitioner* and *hospital*, the reason for the hospitalization and any other information needed to complete the review. In some cases, you may be asked for more information or a second opinion may be required to complete the review.

Preauthorization – Preauthorization is necessary to determine if certain services and supplies are covered under this plan and if you meet the plan's eligibility requirements. PacificSource reviews new technologies and standards of medical practice on an ongoing basis and therefore the list of preauthorization requirements is subject to changes and updates. The current list of procedures and services that require preauthorization under the plan can be found the PacificSource' website: psa.pacificsource.com.

The list of services that require preauthorization is not intended to suggest that all the items included are necessarily covered by the benefits of this plan.

A request for preauthorization must be made to PacificSource as soon as the patient knows that he or she will be receiving services for which preauthorization is required. Your medical provider can request preauthorization from PacificSource by phone – (888) 532-5332, fax – (503) 670-8263, or mail:

PacificSource Administrators, Inc.
PO Box 70088, Springfield OR 97475
Phone (503) 670-8263 or (888) 532-5332
Español (800) 624-6052, extensión 1009
asocustomerservice@pacificsource.com

If your provider will not request preauthorization for you, you may contact PacificSource yourself. In some cases, you may be asked for more information or be required to obtain a second opinion before a benefit determination can be made.

If you are preauthorized for one facility, but are then transferred to another facility you will need to obtain preauthorization for the new facility before transferring, except in the case of emergencies in which case notification must be made as soon as possible after transferring facilities.

If your provider's preauthorization request is denied as not *medically necessary* or as *experimental*, your provider may appeal the *adverse benefit determination*. You retain the right to appeal the *adverse benefit determination* independent from your provider.

Note: A preauthorization determination is valid for 90 days. However, if your coverage under the plan ends before the services are rendered or supplies received, the preauthorization determination will become invalid.

Case Management

The primary objective of large case management is to identify and coordinate cost-effective medical care alternatives and to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Large case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among *health care providers*, patients and others.

Benefits may be modified by the *Plan Sponsor* to permit a method of treatment not expressly provided for, but not prohibited by law, rules or public policy, if the *Plan Sponsor* determines that such modification is *medically necessary* and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The *Plan Sponsor* also reserves the right to limit payment for services to those amounts which would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Examples of *illnesses* or *injuries* that may be appropriate for large case management include, but are not limited to:

- Terminal *illnesses* (Cancer, AIDS, Multiple Sclerosis, Renal Failure, Obstructive Pulmonary Disease, Cardiac conditions, etc.)
- *Accident* victims requiring long-term rehabilitative care
- Newborns with high-risk complications or multiple birth defects
- Diagnoses involving long-term IV therapy
- *Illnesses* not responding to medical care
- Child and adolescent mental/nervous disorders

- Organ transplants

Individual Benefits Management

Individual benefits management addresses, as an alternative to providing covered services, PacificSource's consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by on a case-by-case basis. The determination to cover and pay for alternative benefits for an individual shall not be deemed to waive, alter or affect the *Plan* Sponsor's or PacificSource's right to reject any other or subsequent request or recommendation. The *Plan Sponsor* may provide alternative benefits if PacificSource and the individual's attending provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, PacificSource concludes that substantial future expenditures for covered services for the individual could be significantly diminished by providing such alternative benefits under the individual benefit management program (See Case Management above).

CLAIMS PROCEDURES

How to File/How to Appeal a Claim

These claim procedures describe how benefit claims and appeals are made and decided under this plan.

Only members or a designated authorized representative may submit claims for benefits (for themselves and on behalf of their covered dependents), and benefits will only be paid to the member or the actual provider of services. Under the following claims procedures section, the words 'you' and 'your' will mean a member of the group health plan of the *Plan Sponsor*. You become a claimant when you make a request for a plan benefit or benefits in accordance with these claims procedures.

You and your covered dependents have the right to elect group health care benefits as offered by the *Plan Sponsor*, and your and their rights will be determined under the plan's provisions and in conjunction with the claims and appeals procedures outlined later in this section. Claims will also be considered filed by you if communications and requests for benefits come from an individual that you have designated as your authorized representative to act on your behalf with respect to a claim. In the event that you designate an authorized representative to act on your behalf, the plan will send all notifications, requests for further information, appeal decisions, and all other communications to your authorized representative and provide you with a copy of all communications, unless you request otherwise in writing.

An authorized representative may act on behalf of a claimant with respect to benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an authorized representative until the plan receives an Designation of Authorized Representative form signed by the claimant, except that for urgent care claims the plan shall, even in the absence of a signed Designation of Authorized Representative form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician or practitioner) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

A Designation of Authorized Representative form may be obtained from and completed forms must be returned to:

PacificSource Administrators, Inc.
PO Box 70088, Springfield OR 97475
Phone (503) 670-8263 or (888) 532-5332
Español (800) 624-6052, extensión 1009
asocustomerservice@pacificsource.com

An assignment for purposes of payment (e.g., to a health professional) does not constitute appointment of an authorized representative under these claims procedures. However, unless you have directed the plan otherwise, claims submitted on your behalf by a health care professional will be considered a valid claim if submitted pursuant to the guidelines outlined in these claim procedures.

Any reference in these claims procedures to the claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.

For the purposes of the claims procedures section, any reference to 'days' will refer to calendar days, not business days.

Questions about Your Claims

PacificSource is available to listen and help with any concerns or problems you may have with resolving a claim. Because PacificSource wants you to be completely satisfied with the member services assistance you receive, a process has been established for addressing your concerns and solving your problems. If you have a concern regarding a person, a service, the quality of care, or you want to inquire about what benefits are covered under the plan, please call PacificSource at (888) 532-5332 and explain your concern to one of their Customer Service Representatives. You may also express that concern in writing. PacificSource will do their best to resolve the matter on your initial contact. If PacificSource needs more time to review or investigate your concern, they will get back to you as soon as possible, but in any case within 30 days. They will not consider any of these communications to be a 'claim' for benefits. A formal claim for benefits must meet certain other standards which are described in greater detail in these procedures.

Types of Claims

Pre-Service Claims – The plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some cases be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider as soon as possible, generally within two working days, but no later than 15 days within receipt of the request.

Urgent Care Claims – If the time period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 72 hours within receipt of the request.

Concurrent Care Review – A concurrent care decision occurs when a previously approved course of treatment is reconsidered and reduced or denied, or where an extension is requested beyond the initially approved period of time or number of treatments. Inpatient hospital or rehabilitative facilities, skilled nursing facilities, intensive outpatient, and residential behavioral health care require concurrent review for a benefit determination with regard to an appropriate length of stay or duration of service. Benefit determinations will be made as soon as possible within receipt of all the information necessary to make such a determination.

Post-Service Claims – A claim determination that involves only the potential payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than 30 days from the day after receiving the claim.

How to File a Claim

Most health care providers will file claims on your behalf. Electronically submitted claims are processed most efficiently. If unable to file electronically, you, your health care provider, or an authorized representative must file your claim using HCFA-1500 (revision 12/90 and later), UB92, or ADA (revision 12/90 and later) forms, or an itemized statement. These forms are available from your health care provider or PacificSource.

A claim will be considered filed when it is received by PacificSource at the address listed below:

PacificSource Administrators, Inc.
PO Box 70088, Springfield OR 97475
Phone (503) 670-8263 or (888) 532-5332
Español (800) 624-6052, extensión 1009
asocustomerservice@pacificsource.com

The following information is required in order qualify your request for benefits as a properly submitted claim:

- Plan *member's* name, member ID and current address;
- Patient's name, member ID and address if different from the *member's*;
- Provider's name, tax identification number, address, degree and signature;
- Date(s) of service(s);
- Place of service(s);

- Diagnostic Code;
- Procedure Codes (describes the treatment or services rendered);
- Assignment of Benefits, signed (if payment is to be made to the provider);
- Release of Information Statement, signed; and
- Explanation of Benefits (EOB) information if another plan is the primary payer.

This plan also recognizes the following actions and submission of forms as claims:

- A request by you for benefits through preauthorization or a utilization review determination in cases where use of either preauthorization or utilization review is required in order to obtain a particular benefit.
- Requests by your formally-designated authorized representative for preauthorization or utilization review determination in cases where use of either preauthorization or utilization review is required in order to obtain a particular benefit. The plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances, and the plan will require that you complete and file a form identifying any person you authorize to act on your behalf with respect to a claim. However, when inquiries by a health care provider relate to payments due to the provider—rather than due to you—under participating provider contracts (where the health care provider has no recourse against you for the amounts) such inquiries by a health care provider will not be considered 'claims' by the plan.
- Requests for benefits (in the case of a claim involving urgent care) by a health care provider with knowledge of your medical condition. For urgent care claims, you are not required to complete a form and formally designate a health care provider as your representative with respect to a claim.

Claims must be submitted individually for each claimant. Please do not staple claims together. Send completed information to:

PacificSource Administrators, Inc.
PO Box 70088, Springfield OR 97475
Phone (503) 670-8263 or (888) 532-5332
Español (800) 624-6052, extensión 1009
asocustomerservice@pacificsource.com

If you have any questions regarding your eligibility, benefits or claims information, please call PacificSource at: (888) 532-5332.

All claims for benefits must be submitted to the plan within 90 days of the date of service. If it is not possible to submit a claim within 90 days, you should submit the claim as soon as possible. In some cases the plan will accept the late claim. The plan, however, will not pay a claim that was submitted more than one year after the date of service.

All submitted claims and appeals will fall into one of the categories described previously. The handling of your initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time your claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

Pre-service claims – Your plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some case be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider as soon as possible, generally within two working days, but no later than 15 days within receipt of the request.

Urgent care claims – If the time period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 72 hours of receipt of the request.

Concurrent care review – Inpatient hospital or rehabilitation facilities, skilled nursing facilities, intensive outpatient, and residential behavioral healthcare require concurrent review for a benefit determination with regard to an appropriate length of stay or duration of service. Benefit determinations will be made as soon as possible but no later than one working day after receipt of all the information necessary to make such a determination.

Post-service claims – A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than 30 days from the day after receiving the claim.

Retrospective review – A claim for benefits for which the service or supply requires a preauthorization review but was not submitted for review on a pre-service basis will be reviewed on a retrospective basis within 30 working days after receipt of the information necessary to make a claim determination.

Extension of time – Despite the specified timeframes, nothing prevents the member from voluntarily agreeing to extend the above timeframes. Unless additional information is needed to process your claim, PacificSource will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for urgent care claims.

Extension of time – Unless additional information is needed to process your claim, the plan will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed. If they do not receive the necessary information within 15 days of the delay notice, they will either deny the claim or notify you every 45 days while the claim remains under investigation.

Adverse benefit determinations – Any denial, reduction or termination of, or failure to provide or make a payment for a benefit based on:

- A determination that the member is not eligible to participate in the plan.
- A determination that the benefit is not covered by the plan.
- The imposing of limits, such as preexisting condition or source-of-injury exclusions.
- A determination that the benefit is experimental, investigational or not medically necessary or medically appropriate.

An adverse benefit determination made to reduce or deny benefits applied for a pre-service, post-service, or concurrent care basis may be appealed in accordance with the plan's appeals procedures described later in this section.

Incomplete Claims

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

Other Incomplete Claims – If a pre-service or post-service claim is incomplete, the plan may deny the claim or may take an extension of time, as described above. If the plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the plan. If the requested information is provided, the plan shall decide the claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

If you fail to follow the plan's filing procedures because your request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; or 4) is not sent to the correct address, you will not have submitted a claim. You will be notified orally, and/or by written notification if requested by the claimant, within 24 hours, that you have failed to follow the filing procedures, and you will be reminded of the proper filing procedures.

Notification of Benefit Determination

The plan will pay the benefit according to plan provisions. This may mean that less than 100% of your claim is payable by the plan. In each case where the plan pays benefits or determines that it is not responsible for your medical claim, you will receive an Explanation of Benefits which will outline the basis for the plan's payment. If your claim is denied or payable at a level less than outlined in this Summary Plan Description, you are entitled to appeal the decision under the rules governing adverse benefit determination.

Adverse Benefit Determination

Written notification will be provided to you of the plan's adverse benefit determination (as defined in the How To File A Claim section above) and will include the following:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), as well as how to obtain the diagnosis code, the treatment code, and the corresponding meanings of these codes.
- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
- If the determination involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.

Notification of the plan's adverse benefit determination on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

You may call the Third Party Administrator at (888) 532-5332 to discuss the adverse benefit determination if you have concerns. You may also express those concerns in writing and if needed, may submit additional information that you believe would clarify any of the circumstances that lead to the adverse benefit determination. Third Party Administrator will not consider any of these questions or clarifications to be a formal appeal unless you specifically state it as such. The process for filing a formal appeal is listed below.

Your Right to Appeal

You have the right to appeal an adverse benefit determination under these claims procedures. If you choose to appeal the plan's adverse benefit determination, your appeal will be governed by rules that assure you a full and fair review.

If you are denied benefits based upon the plan's finding that you are/were ineligible for benefits, the denial of benefits gives you the opportunity to appeal the plan's decision.

If the plan decides to reduce or terminate benefits for your previously-approved course of treatment, the plan's decision will be treated as an adverse benefit determination, and the plan will provide you reasonable advance notice of the reduction or termination to allow you to appeal the plan's decision before the benefit reduction or termination takes place. If you decide to appeal the plan's decision, you must follow the rules for appealing a plan's decision.

No lawsuit can be instituted until the claimant has exhausted the plan's internal and external claims review and appeals procedures. No lawsuit can be instituted more than one year after the date of the notice to the claimant that a claim appeal has been denied.

Appealing an Initial Claim Determination – You must submit a written request to the plan within 180 days of receipt of an adverse benefit determination in order to initiate an appeal. An oral request for review is acceptable for urgent care claims and may be made by calling the Third Party Administrator at (888) 532-5332 and asking the plan to register your oral appeal.

When you appeal an adverse benefit determination, the plan will provide a full and fair review which will include the following features:

- You will have the opportunity to submit written comments, documents, records, and other information related to the claim.
- At your request (and free of charge), you will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to your claim for benefits. Included in this category are any documents, records or other information in your claim file, whether or not those materials were relied upon by the plan in making its adverse benefit determination. You also have the right to review documentation showing that the plan followed its own internal processes for ensuring appropriate decision making.
- The review of your claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial benefit determination.
- Any appeal of an adverse benefit determination will not give deference to the initial decision on your claim, and the review will be conducted by a designated plan representative who did not make the original determination and does not report to the plan representative who made the original determination.
- In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or medically appropriate), the designated plan representative will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination. The plan will uphold the findings of the independent review in responding to the appeal.
- The plan will identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination of your claim, whether or not that advice was relied upon in making the benefit determination.

You must first follow this appeal process before taking any outside legal action. After you submit the claim for appeal, the plan will make a decision on your appeal as follows:

Appeal of Urgent Care Claims – The plan's expedited appeal process for urgent care claims will allow you to request (orally or in writing) an expedited appeal, after which, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, fax, or other expeditious method. You will be notified (in writing or electronically) of the benefit determination as soon as possible, but not later than 72 hours after the plan receives the request for review of the prior benefit determination. For urgent care claims you may also be able to request an independent external review take place at the same time as you pursue the plan's internal appeal process.

Appeal of Non-Urgent Pre-Service Claims – For non-urgent pre-service claims, you will be notified (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days.

Appeal of Concurrent Care Claims – For concurrent care claims, you will be notified (in writing or electronically) of the benefit determination with reasonable advance notice before the benefit reduction or termination takes place.

Appeal of Post-Service Claims – For post-service claims, you will be notified (in writing or electronically) of the benefit determination within a reasonable period of time, but not later than 60 days.

Denial of Claim on Appeal – If your appealed claim is denied, the plan will send you written or electronic notification that explains why your appealed claim was denied and shall include the following:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the determination is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
- If the determination involves scientific or clinical judgment, the plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- A statement indicating your right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in your claim file, whether or not those materials were relied upon by the plan in making its adverse determination.

Additional Level of Review – If you are dissatisfied with the outcome of your appeal, you may request an additional review. To initiate this review you should follow the same process required for an appeal. You must submit a written request for additional review **within 60 days** following the receipt of the appeal decision.

When you submit a request for additional review of an adverse benefit determination, the plan will provide a full and fair review which will include the following features:

- You will have the opportunity to submit written comments, documents, records, and other information related to the claim.
- At your request (and free of charge), you will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to your claim for benefits. Included in this category are any documents, records or other information in your claim file, whether or not those materials were relied upon by the plan in making its adverse benefit determination. You also have the right to review documentation showing that the plan followed its own internal processes for ensuring appropriate decision making.
- The review of your claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Additional review will not afford deference to the appeal determination, and the review will be conducted by a designated plan representative who did not make the original determination and does not report to the plan representative who made the original determination.
- In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or medically appropriate), the designated plan representative will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination. The plan will uphold the findings of the independent review in responding to the appeal.
- The plan will identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination of your claim, whether or not that advice was relied upon in making the benefit determination.

After you submit the claim for additional review, the plan will make a decision on your appeal as follows:

Additional Review of Urgent Care Claims – The plan's expedited additional review process for urgent care claims will allow you to request (orally or in writing) an expedited review, after which, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, fax, or other expeditious method. You will be notified (in writing or electronically) of the benefit determination as soon as possible, but not later than 72 hours after the plan receives the request for the review.

Additional Review of Non-Urgent Pre-Service Claims – For non-urgent pre-service claims, you will be notified (in writing or electronically) of the review outcome within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days.

Additional Review of Concurrent Care Claims – For concurrent care claims, you will be notified (in writing or electronically) of the review outcome with reasonable advance notice before the benefit reduction or termination takes place.

Additional Review of Post-Service Claims – For post-service claims, you will be notified (in writing or electronically) of the review outcome within a reasonable period of time, but not later than 60 days.

Denial of Claim after Additional Review – If after your request for additional review the claim is denied, the plan will send you written or electronic notification that explains why the additional review upheld the denial and shall include the following:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the determination is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
- If the determination involves scientific or clinical judgment, the plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- A statement indicating your right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in your claim file, whether or not those materials were relied upon by the plan in making its adverse determination.

Independent External Review – You may have the right to have your case reviewed by an external independent review organization. Only decisions that are based on issues related to medical necessity, medical appropriateness, health care setting, level of care, or effectiveness of a covered benefit may be appealed to an external independent review organization. The plan must contract with at least three different independent external review organizations and must rotate between them on a random or circulating basis.

Your request for an independent review must be made in writing to PacificSource within 180 days of the date of the final internal adverse benefit determination. You may include additional written information, which will be included with the documents PacificSource provides to the independent review organization.

A final decision made by an independent review organization is binding on the *Plan Sponsor*. This decision is also binding on you, except to the extent other remedies are available under state or federal law.

In certain instances you may be able to request an expedited review process, such as when the timeframe for completion of the internal appeals process would seriously jeopardize the life or health of the claimant or their ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a facility.

Resources For Information And Assistance

Assistance in Other Languages

Members who do not speak English may contact PacificSource's Customer Service Department for assistance. They can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

Information Available from PacificSource

PacificSource makes the following written information available to you free of charge. You may contact their Customer Service Department by phone, mail, or email to request any of the following:

- A directory of participating healthcare providers under your plan

- Information about our drug formulary
- A copy of our annual report on complaints and appeals
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration) of any risk-sharing arrangements we have with providers
- A description of our efforts to monitor and improve the quality of health services
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers
- Information about our preauthorization and utilization review procedures
- Information about any healthcare plan offered by the *Plan Sponsor*

Information Available from the Oregon Insurance Division

The following consumer information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys
- A summary of our health promotion and disease prevention activities
- Samples of the written summaries delivered to PacificSource policyholders
- An annual summary of grievances and appeals against PacificSource
- An annual summary of our utilization review policies
- An annual summary of our quality assessment activities
- An annual summary of the scope of our provider network and accessibility of healthcare services

You can request this information by contacting the Oregon Insurance Division by writing to the Oregon Insurance Division, Consumer Advocacy Unit, PO Box 14489, Salem, OR 97309-0405 or by phone at (503) 947-7984, or the toll-free message line at (888) 877-4894, on the Internet at http://insurance.oregon.gov/consumer/consumer.html, or by email at cp.ins@state.or.us.

Plan Sponsor's **Discretionary Authority; Standard of Review**

The *Plan Sponsor* is the sole fiduciary of the plan, and exercises all discretionary authority and control over the administration of the plan and the management and disposition of plan assets. Benefits under the plan will be paid only if the *Plan Sponsor* decides, in its discretion, that the member or beneficiary is entitled to such benefits. Any construction of the terms of any plan document and any determination of fact adopted by the *Plan Sponsor* shall be final and legally binding on the parties. A court of law or arbitrator reviewing any fiduciary's decision, including one relating the plan interpretation or a benefit claim, must consider only the documents, testimony and other evidence that were presented to the fiduciary at the time the fiduciary made the decision. In addition, the court or arbitrator must use the 'arbitrary and capricious' standard of review. That is, the fiduciary's determination can be reversed only if it was made in bad faith, is not supported by substantial evidence or is erroneous as to a question of law.

The *Plan Sponsor* may hire someone to perform claims processing and other specified services in relation to the plan. Any such contractor will not be a fiduciary of the plan and will not exercise any of the discretionary authority and responsibility granted to the *Plan Sponsor*, as described above.

Coordination of Benefits

Coordinating with Other Group Health Plans – When benefits are coordinated, one plan pays benefits first (the 'primary coverage') and the other plan pays benefits second (the 'secondary coverage').

When you and/or your dependents are covered under more than one group health plan, the combined benefits payable by this plan and all other group plans will not exceed 100% of the eligible expense incurred by the individual. The plan assuming primary payer status will determine benefits first without regard to benefits provided under any other group health plan.

Note: If your primary and secondary coverage both include a deductible, you will be required to satisfy each of those deductibles before benefits will be paid.

There are two types of Coordination of Benefits – 'True' Coordination of Benefits and Non-Duplicating Coordination of Benefits (also called Integration of Benefits.) See the Medical Benefit Summary to determine if your plan offers True Coordination of Benefits or Non-Duplicating/Integration of Benefits.

For **True Coordination of Benefits**, the primary plan will pay benefits first, subject to any deductibles, copayments and coinsurance. The remaining balance will be passed on to the secondary payer. When this plan is the secondary payer, the balance of eligible expenses will be applied as if it was a new claim under this plan. Deductibles, copayments and coinsurance relevant to this plan will be subtracted from the amount before paying the remainder.

For **Non-Duplicating Coordination of Benefits/Integration of Benefits**, the primary plan will pay benefits first, subject to any deductibles, copayments and coinsurance. The remaining balance will be passed on to the secondary payer. When this plan is the secondary payer, it will reimburse the balance of remaining eligible expenses, not to exceed normal plan liability if this plan had been primary. This means that if the primary payer has already paid as much as or more than this plan would have paid had this plan been primary, there will be no additional payment made.

Government Programs and Other Group Health Plans -The term group health plan, as it relates to coordination of benefits, includes the government programs Medicare, Medicaid and TriCare. The regulations governing these programs take precedence over the determination of benefits under this plan. For example, in determining the benefits payable under the plan, the plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a Medicaid plan.

The term group health plan also includes all group insurance and group subscriber contracts, such as union welfare plans.

Order of Payment When Coordinating with Other Group Health Plans:

- If the other plan does not include 'coordination of benefits,' that plan is primary and this plan is secondary.
- If you are covered as an employee on one plan and a dependent on another, your employer's plan is primary.
- When a child is covered under both parents' policies and the parents are either married or are living together (regardless of whether or not they have ever been married):
  - The parent whose birthday falls first in a calendar year has the primary plan; or
  - If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
- When a child is covered under both parents' plans and the parents are divorced, separated, or not living together (regardless of whether or not they have ever been married):
  - If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.
  - If a court order specifies that both parents are responsible for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If a court order specifies that both parents have joint custody without specifying that one parent has responsibility for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.

- If there is no court order, the order of benefits for the child are as follows:
  - The custodial parent's coverage is primary;
  - The spouse of the custodial parent's coverage pays second;
  - The natural parent without custody's coverage pays third; and
  - The spouse of the natural parent without custody's coverage pays fourth.

- If a plan covers you as an active employee or a dependent of an active employee, that plan is primary. Another plan covering you as inactive, laid off, or retired is secondary.
- When this plan covers you or your dependent pursuant to COBRA or under a right of continuation pursuant to other federal law, the plan covering you or your dependent as an employee, member, subscriber, or retiree or covering you or your dependent as a dependent of an employee, member, subscriber or retiree is the primary plan and this plan's coverage is the secondary plan.
- If none of these rules apply, the coverage that has been in place longest is primary.

Most insurers or administrators send you an explanation of benefits, or EOB, when they pay a claim. If your other plan's coverage is primary, send PacificSource the other plan's EOB with your original bill and they will process your claim. If you receive more than you should when your benefits are coordinated, you will be expected to repay any over-payment to the plan.

Right to Make Payments to Other Organizations - Whenever payments, which should have been made by this plan, have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

Automobile Insurance – This plan provides benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis only. Benefits payable under this plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by this plan will be subject to the plan's reimbursement and/or subrogation provisions.

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits

All benefits payable by the plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. However, the plan reserves the right to reimburse the member, the provider, or both jointly. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

Members are expressly prohibited from assigning any right to payment of benefits under a Benefit Program, including this plan. No attempts at assignment of any such expenses under a Benefit Program will be recognized. Except as may be expressly prescribed in an agreement to which the *Plan Sponsor* is a party, nothing contained in any written designation of coverage under a Benefit Program will make the Benefit Program, or the *Plan Sponsor* or any other employer, liable to any third-party to whom a member may be liable for medical care, treatment or services.

Proof of Loss

The *Plan Sponsor* has the right to require a claimant to undergo physical or psychological examinations relating to the claimant's illness, injury or condition as often as the *Plan Sponsor* deems reasonably necessary while the claim for benefits is pending. The *Plan Sponsor* also has the right to require an autopsy in case of death (where not prohibited by law).

No Verbal Modifications of Plan Provisions

No verbal statement made by anyone involved in administering this plan can waive any of the terms or conditions of this plan or prevent the *Plan Sponsor* from enforcing any provision of this plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of the *Plan Sponsor*. Any such written waiver will be valid only as to the specific plan, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time, and will not be a continuing waiver of the term or condition in the future.

Reimbursement to the Plan

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict or otherwise, for an illness or injury. In that case, you or your dependent (or the legal representatives, estate or heirs of either you or your dependent), must promptly reimburse the plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). If the plan has not yet paid benefits relating to that illness or injury, the plan may reduce or deny future benefits on the basis of the compensation received by you or your dependent.

Benefits relating to such illness or injury will not be payable by the plan until you sign and return a statement, provided by the plan, acknowledging your obligation to reimburse the plan under this provision. That obligation will arise upon the payment of any plan benefits relating to the illness or injury, whether or not you sign such a statement.

You or your dependent must cooperate with the plan and its authorized representatives, and must sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement. You or your dependent must also provide any relevant information and take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the plan's right of reimbursement.

In order to secure the rights of the plan under this section, you or your dependent hereby: (1) grant to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you or your dependent; and (2) assign to the plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the *Plan Sponsor*, in the exercise of its sole discretion.

This plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the plan from receiving a recovery unless a member has been 'made whole' with regard to illness or injury that is the responsibility of a third party. This plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this plan, since the plan's recovery rights apply to the first dollars payable by a third party.

Subrogation

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for you or your dependent's illness or injury and the plan has paid benefits related to that illness or injury.

The plan is subrogated to all of the rights of you or your dependent against any party liable for you or your dependent's illness or injury to the extent of the reasonable value of the benefits provided to you or your dependent under the plan. The plan may assert this right independently of you or your dependent.

You and your dependent are obligated to cooperate with the plan and its authorized representatives in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the plan under this section.

The costs of legal representation of the plan in matters related to subrogation will be borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, or were made in error by the plan, the plan has the right to recover these payments from any individual (including yourself), insurance company or other organization to whom the payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered. If excess or erroneous payments were made for services rendered to your dependent(s), the plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

In the same manner, if the plan applies medical expenses to the plan deductible that would not otherwise be reimbursable under the terms of this policy; the plan may deduct a like amount from the accumulated deductible amounts and/or recover payment of medical expenses that would have otherwise been applied to the deductible. The fact that a medical expense was applied to the plan's deductible, or that a drug was provided under the plan's prescription drug program, does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

Right To Receive and Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions, including medical information. When you request benefits, you must either furnish or authorize the release of all the information required to implement plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits and the plan will have no further liability for such benefits.

Under normal conditions, benefits are payable to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The plan must make payments to your separated/divorced spouse, state child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

Reliance on Documents and Information

Information required by the *Plan Sponsor* or PacificSource may be provided in any form or document that the *Plan Sponsor* and PacificSource considers acceptable and reliable. The *Plan Sponsor* and PacificSource relies on the information provided by you and others when evaluating coverage and benefits under the plan. All such information, therefore, must be accurate, truthful and complete. The *Plan Sponsor* and PacificSource is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the *Plan Sponsor* or PacificSource. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan.

No Waiver

The failure of the *Plan Sponsor* to enforce strictly any term or provision of this plan will not be construed as a waiver of such term or provision. The *Plan Sponsor* reserves the right to enforce strictly any term or provision of this plan at any time.

Physician/Patient Relationship

This plan is not intended to disturb the physician/patient relationship. Physicians, practitioners and other health care providers are not agents or delegates of the *Plan Sponsor*, or the Third Party Administrator. Nothing contained in this plan will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in this plan will limit or otherwise restrict a physician or practitioner's judgment with respect to the physician or practitioner's ultimate responsibility for patient care in the provision of medical services to you or your dependent.

Plan not responsible for Quality of Health Care

You and your enrolled dependents have the right to select your health care provider. Neither the plan, your *Plan Sponsor*, nor Third Party Administrator is responsible for the quality of care received and cannot be held liable for any claim or damages connected with injuries suffered while receiving health services or supplies.

Plan is not a Contract of Employment

Nothing contained in this plan will be construed as a contract or condition of employment between the *Plan Sponsor* and any employee. All employees are subject to discharge to the same extent as if this plan had never been adopted.

Right to Amend or Terminate Plan

Plan Sponsor reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time.

If changes occur, your *Plan Sponsor* will notify you of changes to your plan.

If your health *plan* terminates and your *Plan Sponsor* does not replace the coverage with another group policy, your *Plan Sponsor* is required by law to advise you in writing of the termination. When this *plan* terminates, your *Plan Sponsor* will notify you about any available options for you to continue your coverage.

The *Plan Sponsor* may pay your medical claims if a workers' compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal. But before we do that, you must sign a written agreement to reimburse the *Plan Sponsor* any money you recover from the workers' compensation coverage.

Rescissions

The *Plan Sponsor* or PacificSource may not rescind the coverage of a member unless the member, or person seeking coverage on behalf of the member, performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan and the *Plan* Sponsor or PacificSource gives the member a 30-day prior written notice. PacificSource may not rescind the policyholder's group health benefit plan unless the policyholder, or representative of the policyholder, performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan and PacificSource gives a 30-day prior written notice to all member covered under the plan. Rescissions do not include a cancellation or discontinuance of coverage that is prospective or to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage.

Applicable Law

This is a self-insured benefit plan. As such, Federal law preempts State law and jurisdiction. To the extent not preempted by federal law, the laws of the state of Oregon shall apply.

NOTICE OF PRIVACY PRACTICES

This notice is intended to bring the City of Springfield Employee Benefit Plan into compliance with the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the 'HIPAA Privacy Rule') by establishing the conditions under which the *Plan Sponsor* will receive, use and/or disclose protected health information.

Permitted Disclosures of Protected Health Information to the *Plan Sponsor*

Subject to the conditions of the 'No Disclosure of Protected Health Information to the Employer Without Certification by Employer' and 'Conditions of Disclosure of Protected Health Information to the Employer', the plan (and any third party administrator or business associate acting on behalf of the plan) may disclose individuals' protected health information to the *Plan Sponsor* for the *Plan Sponsor* or PacificSource to carry out plan administration functions. The plan (and any third party administrator or business associate acting on behalf of the plan) may not disclose individuals' protected health information to the *Plan Sponsor* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor*.

No Disclosure of Protected Health Information to the *Plan Sponsor* without Certification by *Plan Sponsor*

Except as provided below in 'Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the Employer,' with respect to the plan's disclosure of summary health information and enrollment/disenrollment information, the plan will not disclose protected health information to any employee of the *Plan Sponsor*.

Conditions of Disclosure of Protected Health Information to the *Plan Sponsor*

The *Plan Sponsor* certifies that the plan has been amended to incorporate this section and agrees to the following restrictions and conditions of receiving protected health information (other than summary health information or enrollment/disenrollment information as explained in 'Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the *Plan Sponsor*' below). The *Plan Sponsor* shall:

- Not use or further disclose the protected health information other than as permitted or required herein or as required by law.
- Ensure that any agent(s), including a subcontractor, to whom it provides protected health information received from the plan agrees to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such protected health information.
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor*.
- Report to the plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware.
- Make available protected health information to comply with an individual's right to access protected health information in accordance with 45 C.F.R. Section 164.524.
- Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. Section 164.526.
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528.
- Make its internal practices, books and records relating to the use and disclosure of protected health information received from the plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA Privacy Rule.
- If feasible, return or destroy all protected health information received from the plan that the *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the *Plan Sponsor* will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the required adequate separation, described in 'Required Separation Between the Plan and the *Plan Sponsor*' below, is established and maintained.

Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the *Plan Sponsor*

- The plan (or a third party administrator of the plan) may disclose summary health information to the *Plan Sponsor* without the need to comply with the conditions and restrictions of 'No Disclosure of Protected Health Information to the *Plan Sponsor* Without Certification by *Plan Sponsor*' and 'Conditions of Disclosure of Protected Health Information to the *Plan Sponsor*', if the *Plan Sponsor* requests the summary health information for the purpose of:
  - Obtaining premium bids from health plans (including health insurance issuers) for providing health insurance coverage under the plan; or
  - Modifying, amending, or terminating the plan.
- The plan (or a third party administrator of the plan) may disclose information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from the plan without the need to comply with the conditions and restrictions of 'No Disclosure of Protected Health Information to the *Plan Sponsor* Without Certification by *Plan Sponsor*' and 'Conditions of Disclosure of Protected Health Information to the *Plan Sponsor*'

Required Separation between the Plan and the *Plan Sponsor*

- The following classes of employees or other persons under the control of the *Plan Sponsor* will have access to protected health information received from the plan (or from a health insurance issuer with respect to the plan):
  - Human Resources
- No other persons shall have access to protected health information. The listed classes of employees or other persons under the control of the *Plan Sponsor* will have access to protected health information solely to perform the plan administration functions that the *Plan Sponsor* performs for the plan. They will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the *Plan Sponsor*) for any use or disclosure of protected health information in violation of the provisions of this plan.

DEFINITIONS

Wherever used in this plan, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. For the purpose of this plan, 'employee' includes the *Plan Sponsor* when covered by this plan. Other terms are defined where they are first used in the text.

Accident means an unforeseen or unexpected event causing injury that requires medical attention.

Actively at work or active employment means that an employee is performing in the customary manner all of the regular duties of his/her occupation with the *Plan Sponsor*, either at one of the *Plan Sponsor*'s regular places of business or at some location to which the *Plan Sponsor*'s business requires the employee to travel to perform his/her regular duties assigned by the *Plan Sponsor*. An employee is also considered to be actively at work on each day of a regular paid vacation or non-work day, but only if the employee is performing in the customary manner all of the regular duties of the employee's occupation with the *Plan Sponsor* on the immediately preceding regularly scheduled workday.

Advanced diagnostic imaging means diagnostic examinations using CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies.

Adverse benefit determination means a denial, reduction, or termination of a healthcare item or service, or a failure or refusal to provide or to make a payment in whole or in part for a healthcare item or service, that is based on the *Plan Sponsor*'s or PacificSource's:

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of a policy or coverage;
- Imposition of a source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

- Determination that a healthcare item or service is experimental, investigational, or not medically necessary, effective, or appropriate; or

- Determination that a course or plan of treatment that a member is undergoing it an active course of treatment for purposes of continuity of care under ORS 743.854.

Allowable fee is the dollar amount established by the plan for reimbursement of charges for specific services or supplies provided by *nonparticipating providers*. The plan uses several sources to determine the *allowable amount*. Depending on the service or supply and the geographical area in which it is provided, the *allowable amount* may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, other nationally recognized databases, or PacificSource.

Where the provider network is deemed adequate, the allowable fee for professional services is based on PacificSource's standard participating provider reimbursement rate or a contracted reimbursement rate. Outside the PacificSource service area and in areas where the participating provider network is not deemed adequate, the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

Ambulatory surgical center means a facility licensed by the appropriate state or federal agency to perform surgical procedures on an outpatient basis.

Ancillary Services means service rendered in connection with Inpatient or Outpatient care in a *Hospital* or in connection with a medical emergency, such as assistant surgeon, anesthesiology, ambulance, pathology and radiology.

Approved clinical trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life-threatening condition or disease.

Authorized representative is an individual who by law or by the contest of a person may act on behalf of the person.

Calendar year means the 12-month period beginning on each January 1 and ending on the next December 31.

Cardiac rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

Certificate of Creditable Coverage means a certificate or other documentation that shows previous health insurance coverage for a *member* and can be used to reduce the length of any pre-existing condition exclusions under a plan. See *Creditable coverage*.

Chemical dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco products or foods.

Claims Administrator means the organization selected by the City of Springfield to provide claims processing and adjudication under their plans. The Claims Administrator for the their medical, vision and pharmacy coverage is PacificSource.

Contracted amount means the amount that *participating providers* have contracted to accept as payment in full for covered expenses under the plan.

Copayment or coinsurance is the out-of-pocket amount a member is required to pay to a provider.

Creditable coverage means a member's prior health coverage that meets the following criteria:

- There was no more than a 63-day break between the last day of coverage under the previous policy and the first day of coverage under this policy. The 63-day limit excludes the *Plan Sponsor's* eligibility waiting period.

- The prior coverage was one of the following types of insurance: group coverage (including Federal Employee Health Benefit Plans and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, TRICARE, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public health plans.

Custodial Care means non-medical care that is primarily to assist with activities of daily living, whether or not the care is administered by a licensed provider.

Deductible means the portion of the healthcare expense that must be paid by the member before the benefits of this plan are applied.

Dentist means a person acting within the scope of their license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Durable medical equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a person in the absence of an illness or injury; is appropriate for use in the home; and is prescribed by a physician. Examples of durable medical equipment include but are not limited to hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, TENS units, and hearing aids.

Elective surgery or procedure refers to a surgery or procedure for a condition that does not require immediate attention and for which a delay would not have a substantial likelihood of adversely affecting the health of the patient.

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  - Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
  - Result in serious impairment to bodily functions; or
  - Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means, with respect to an emergency medical condition:

- An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

Employee means any individual employed by an employer.

Enrollee means an employee, dependent of the employee, or individual otherwise eligible and enrolled for coverage under this plan. In this policy, enrollee is referred to as subscriber or member.

Essential health benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential health benefits fall into the following categories:

- Ambulatory patient services;

- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Exclusion period means a period during which specified conditions, treatments or services are excluded from coverage.

Experimental or investigational procedures means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are experimental or investigational for the diagnosis and treatment of illness or injury.

- Experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (e.g., FDA) for other than experimental, investigational, or clinical testing;
  - Are not of generally accepted medical practice in the state of Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be experimental or investigational, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are investigational or experimental, PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External review by an independent review organization.
- The following will be considered in making the determination whether the service is in an experimental and/or investigational status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;

- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

Formulary is a list of approved brand name medications used to treat various medical conditions. The formulary list is developed by the pharmacy benefits management company and PacificSource.

Generic drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider and are not a brand name medication. By law, generic drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart.

Grievance means:

- **A request submitted by a member or an authorized representative of a member;**
  - In writing, for an internal appeal or an external review; or
  - In writing or orally, for an expedited internal review or an expedited external review; or
- A written complaint submitted by a member or an authorized representative of a member regarding:
  - The availability, delivery, or quality of a healthcare service;
  - Claims payment, handling, or reimbursement for healthcare services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or
  - Matters pertaining to the contractual relationship between a member and PacificSource.

Health care provider means a *physician*, *practitioner*, nurse, *hospital* or *specialized treatment facility* as defined in this document.

Health benefit plan means any hospital expense, medical expense, or hospital or medical expense policy or certificate, healthcare contractor or health maintenance organization subscriber contract, or any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that plan is subject to state regulation.

Hearing aids mean any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Hearing aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

Homebound means the ability to leave home only with great difficulty with absences infrequently and of short duration. Infants and toddlers will not be considered homebound without medical documentation that clearly establishes the need for home skilled care. Lack of transportation is not considered sufficient medical criterion for establishing that a person is homebound.

Hospital means an institution licensed as a 'general hospital' or 'intermediate general hospital' by the appropriate state agency in the state in which it is located.

Illness includes a physical or mental condition that results in a covered expense. Physical illness is a disease or bodily disorder. Mental illness is a psychological disorder that results in pain or distress and substantial impairment of basic or normal functioning.

Incurred expense means charges of a healthcare provider for services or supplies for which a member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the supply is delivered.

Initial enrollment period means a period of 31 days following the date an individual is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused solely by external and accidental means and does not include muscular strain sustained while performing a physical activity.

Inquiry means a written request for information or clarification about any subject matter related to the member's health benefit plan.

Internal appeal means a review by PacificSource or your *Plan Sponsor* of an adverse benefit determination made by PacificSource.

Leave of absence is a period of time off work granted to an employee by the *Plan Sponsor* at the employee's request and during which the employee is still considered to be employed and is carried on the employment records of the *Plan Sponsor*. A leave can be granted for any reason acceptable to the *Plan Sponsor*, including disability and pregnancy.

Lifetime means the period of time a *member* is enrolled in this plan or any other *Plan sponsored* by the *Plan Sponsor*.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in the state of Oregon, or expert consensus physician opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or injury involved and the patient's overall health condition;
- Not for the convenience of the member or a provider of services or supplies;
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a hospital inpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered medically necessary under this definition (see General Exclusions – Screening tests).

Medical supplies means items of a disposable nature that may be essential to effectively carry out the care a physician has ordered for the treatment or diagnosis of an illness or injury. Examples of medical supplies include but are not limited to syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of this equipment (e.g. Albuterol for use in a nebulizer).

Member means an individual insured through the *Plan Sponsor*.

Mental and/or chemical healthcare facility means a corporate or governmental entity or other provider of services for the care and treatment of chemical dependency and/or mental or nervous conditions which is licensed or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental and/or chemical healthcare program means a particular type or level of service that is organizationally distinct within a mental and/or chemical healthcare facility.

Mental and/or chemical healthcare provider means a person that has met the credentialing requirements of PacificSource, is otherwise eligible to receive reimbursement under the policy and is:

- A healthcare facility where appropriately licensed or accredited by the Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
- A residential program or facility;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Mental or nervous conditions means all disorders listed in the 'Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition' except for:

- Mental Retardation (diagnostic codes 317, 318.0, 318.1, 318.2, 319);
- Learning Disorders (diagnostic codes 315.00, 315.1, 315.2, 315.9);
- Paraphilias (diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9); and
- 'V' codes (diagnostic codes V15.81 through V71.09 – this exception does not extend to children five years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

Network not available means a member does not have reasonable geographic access to a PacificSource participating provider for a medical service or supply.

Nonparticipating provider is a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

Non-formulary drugs are covered brand name medications not on the formulary list.

Orthotic devices means rigid or semirigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for orthotic devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An orthotic device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of orthotic devices include but are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

PacificSource refers to PacificSource Administrators, Inc. PacificSource is the claims administrator of the *Plan Sponsor's* medical, vision and pharmacy coverage. References to PacificSource as paying claims or issuing benefits means that PacificSource processes a claim in accordance with the provisions of the *Plan Sponsor's* plans.

Participating provider means a physician, healthcare professional, hospital, medical facility, or supplier of medical supplies that directly or indirectly holds a provider contract or agreement with the *plan*.

Physical/occupational therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/occupational therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Physician means a state-licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Physician assistant is a person who is licensed by an appropriate state agency as a physician assistant.

Plan means the City of Springfield Employee Benefits Plan, and all documents, including any insurance contracts, administrative service agreements, Summary Plan Descriptions and any related terms and conditions associated with the Plan.

Plan Administrator means the Risk Services Division of the City of Springfield, which has responsibility for the management of the plan.

***Plan Sponsor* ('the *Plan Sponsor*' or 'your *Plan Sponsor*'),** means the City of Springfield. The City of Springfield is the fiduciary of the plan, and exercises all discretionary authority and control over the administration of the plan and the management and disposition of plan assets. The *Plan Sponsor* shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the plan, and benefits under the plan will be paid only if the *Plan Sponsor* decides, in its discretion, that the *member* or beneficiary is entitled to such benefits. The *Plan Sponsor* has the right to amend, modify, or terminate the plan in any manner, at any time, regardless of the health status of any plan *member* or beneficiary.

Plan Year means the twelve-month period of time for the City of Springfield beginning January 1, and ending December 31.

Practitioner means Doctor or Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Licensed Nurse Practitioner (including Certified Nurse Midwife (C.N.M.) and Certified Registered Nurse Anesthetist (C.R.N.A.)), Registered Physical Therapist (R.P.T.), Speech Therapist, Occupational Therapist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist Associate (LPA), Physician Assistant (PA), Audiologist, Acupuncturist, Naturopathic Physician, and Licensed Massage Therapist.

Prescription drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider.

Prosthetic devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for prosthetic devices include coverage of devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a physician's order. Examples of prosthetic devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Qualified domestic partner means a registered domestic partner or unregistered same gender domestic partner with an Affidavit of Domestic Partnership, supplied by the *Plan Sponsor*

Routine costs of care means medically necessary conventional care, items, or services covered by the health benefit plan if typically provided absent a clinical trial. Routine costs of care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the policy if provided outside of a clinical trial;
- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items of services required solely for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by the policy if provided outside of the clinical trial.

Seasonal employee is an employee who is hired with the agreement that their employment will end after a predetermined period of time.

Skilled nursing facility convalescent home means an institution that provides skilled nursing care under the supervision of a physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized treatment facility means a facility that provides specialized short-term or long-term care. The term specialized treatment facility includes ambulatory surgical centers, birthing centers, chemical dependency/substance abuse day treatment facilities, hospice facilities, inpatient rehabilitation facilities, mental and/or chemical healthcare facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, skilled nursing facilities, substance abuse treatment facilities, and urgent care treatment facilities.

Specialty drugs are high dollar oral, injectable, infused or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include but are not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty pharmacies specialize in the distribution of specialty drugs and providing pharmacy care management services designed to assist patients in effectively managing their condition.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step therapy means a program that requires the member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 drugs). The program will not cover a brand name, or second-line medication, until less expensive, firstline/generic medications in the same therapeutic class have been tried first

Surgical procedure means any of the following operative procedures:

- Procedures accomplished by cutting or incision
- Suturing of wounds
- Treatment of fractures, dislocations, and burns
- Manipulations under general anesthesia
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means **Telemedical** means medical services delivered through a two-way video communication that allows a provider to interact with a patient who is at a different physical location than the provider.

Temporomandibular Joint Disorder (TMJ) means any dysfunction or disorder of the jaw joint resulting in pain and impairment of the jaw.

Third Party Administrator is an administrator hired by the *Plan Sponsor* to perform claims processing and other specified administrative services in relation to the plan. The *third party administrator* is not an insurer of health benefits under this plan, is not a fiduciary of the plan, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Sponsor*. The *third party administrator* is not responsible for plan financing and does not guarantee the availability of benefits under this plan. The *third party administrator* is PacificSource Administrators, Inc.

Tobacco use cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco use cessation. Tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Unregistered domestic partner means an individual of the same-gender who is joined in a domestic partnership with the subscriber and meets the following criteria:

- Is at least 18 years of age;
- Not related to the policyholder by blood closer than would bar marriage in Oregon or the state where they have permanent residence and are domiciled;
- Shares jointly the same permanent residence with the policyholder for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
- Has joint financial accounts with the policyholder and has agreed to be jointly responsible with the policyholder for each others' common welfare, including basic living expenses;
- Has an exclusive domestic partnership with the policyholder and has no other domestic partner;
- Does not have a legally binding marriage nor has had another domestic partner within the previous six months;
- Was mentally competent to consent to contract when the domestic partnership began and remains mentally competent.

Urgent care treatment facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Waiting period means the period of time before coverage becomes effective for a *member* who is otherwise eligible to enroll in the plan.

Women's healthcare provider means an obstetrician, gynecologist, physician assistant or nurse practitioner specializing in women's health, or certified nurse midwife practicing within the applicable scope of practice.

RIGHTS OF PLAN *MEMBERS*

MEDICAID AND CHIP STATE CONTACT INFORMATION

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your *Plan Sponsor*, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their *Plan Sponsor*. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for a *Plan Sponsor*-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your *Plan Sponsor* plan, your *Plan Sponsor* must permit you to enroll in your *Plan Sponsor* plan if you are not already enrolled. This is called a 'special enrollment' opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your *Plan Sponsor* plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your *Plan Sponsor* health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid

Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/

	CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

PLAN INFORMATION

Name and Address of the *Plan Sponsor/Plan Sponsor*

City of Springfield
225 Fifth Street
Springfield, OR 97477
541-726-3705

Name and Address of the Designated Agent for Service of Legal Process

Wells Fargo Benefit Group
975 Oak Street, Suite 200
Eugene, OR 97401
(541) 687-2222

Name and Address of the *Third Party Administrator*

PacificSource Administrators, Inc.
PO Box 70088
Springfield, OR 97475-0105
(888) 532-5332
Fax: (503) 670-8263

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 936002258.

Plan Year

The *plan year* is the 12-month period of time beginning January 1 and ending December 31.

Method of Funding Benefits

Health benefits are self-insured from the general assets and or trust funds of the *Plan Sponsor* and are not guaranteed under an insurance policy or contract. The *Plan Sponsor* may purchase excess risk insurance coverage which is intended to reimburse the *Plan Sponsor* for certain losses *incurred* and paid under the plan by the *Plan Sponsor*. Such excess risk coverage, if any, is not part of the plan. The cost of the plan is paid with contributions by the *Plan Sponsor* and participating employees. The *Plan Sponsor* determines the amount of contributions to the plan, based on estimates of claims and administration costs.

Payments out of the plan to *health care providers* on behalf of the covered person will be based on the provisions of the plan.

SIGNATURE PAGE

It is agreed by the City of Springfield that the provisions of this document are correct and will be the basis for the administration of the Preferred Plan.

Dated this _____day of_____, _____

BY_____

TITLE_____

BY_____

TITLE_____